MILITARY PSYCHIATRY IN PEACE AND WAR

C. STANFORD READ

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PREFACE

NOTWITHSTANDING the great opportunities for the study of mental disease arising under active service conditions during the late European War, little English literature on the subject has been published. Though it is more or less universally found that no special war psychosis exists, it has been evident that the environment and circumstances of warfare do tend to bring about certain mental reactions, which, though seen in other situations, are not there so common. Unfortunately the exigencies of war-time precluded most medical officers from devoting time to special study, and my work, as seen in the following pages, has been the product of labour only possible at intervals of leisure now and again. The statistical work at a Clearing Hospital is fraught with much difficulty, for the following up of 3,000 cases which were dispersed over various parts of the United Kingdom is not a task to be lightly undertaken. My medical work during the war has been exceptionally fortunate, in that I have been able to gain a wide experience of the manifold mental abnormalities met with. Previous to my post at " D " Block, Netley, I had charge of neurological wards, and I have had the privilege since of visiting all the War Mental Hospitals in France and Great Britain. My thanks are due to the War Office authorities for giving me official permission and granting me all facilities for those visits. To the various medical officers who so courteously tendered me all available information, and thus helped in my work, I express my indebtedness.

Nowhere in these pages is any dogmatic attitude assumed, though on some points I have strongly favoured certain views. It will soon be evident to the reader that I am a great believer in the psychogenic origin of the majority of the psychoses, and I think that the study of war psychiatry in the light of recent experience shows, firstly, the marvellous adaptability of the human psyche and what an enormous

strain it can bear without resulting harm; and, secondly, that it is in the emotional side of life that we must look for the origin of neuropathic and psychopathic disorders.

I can only hope that the following chapters, which in the past years of hard stress and work would never have been written had it not been for an inherent enthusiasm in the subject, will in some degree help in throwing light upon the intricacies of mental functioning.

In the chapter on " Military Psychiatry during Peace " my facts are largely taken from writings of the American psychiatrist Dr. R. L. Richards, and Lieut.-Colonel Kay, who at one time was in charge of " D " Block, Netley. I am also indebted to Lieut.-Colonel Kay for his kind permission to reproduce the chart and tables in Chapter II., which were published in his paper " Insanity in the Army during Peace and War, and its Treatment." All psychiatrists must be grateful for the excellent and careful bibliography with abstracts which have been arranged and edited by the War Work Committee of the American National Committee of Mental Hygiene. For the preparation of such a work as this these abstracts have been invaluable. My grateful thanks, too, are cordially tendered to my friend Dr. Henry Devine for many helpful suggestions; also to Dr. C. W. Forsyth for aiding me in the statistical work, and my wife for helping the book through the press.

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SALISBURY.

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MILITARY PSYCHIATRY IN PEACE AND WAR

CHAPTER I

THE PSYCHOLOGY OF THE SOLDIER

The past great European War differed largely from all others, in so far as British troops were concerned, in that the ranks were mostly composed, not of professional soldiers, but of civilians who, either by voluntary enrolment or conscription, were rapidly trained as a fighting force. As a natural consequence, therefore, the mentality of these men must have differed greatly in their outlook on service conditions from that of the old regular who had had his mind to some extent prepared for the eventualities of war, and who had become accustomed and adapted to the various conditions of military service. In the army previously we had to deal with a class of men who were specially selected for their health and development, and the inefficient and unstable were soon weeded out; but the recruiting of the civil population in this war by no means paid the necessary attention to mental fitness, so that many highly unadaptable to such a life were enlisted. In times of peace, to some extent, the army had been a refuge for those who could not deal successfully with the conditions of civil life, and this has been partly true also during the war. Though in exceptional cases these "failures" find in the military atmosphere that supervision and restraint which they previously lacked, and which enabled them partly through unconscious suggestion to become fairly useful social members, as a rule this type is not made a man of by military discipline, and he soon shows himself among the delinquent class.

The mental attitude of the civilian towards military service at the time of enlistment is of prime importance to him during the whole of his army career. Many there were who waited for no invitation and for no poster appeals, but with alacrity volunteered their services to the State ; there were those who hesitated much, even apart from their consideration for their dependents: and a third class, even under conscription, did all that was possible to evade being recruited. The very element of fear which inhibited some was in disguise a stimulation to others. For fear has its allurements, and those who inherently have the love of adventure at heart not only face danger when it comes, but advance to meet it. A spice of danger is a fillip to many a man. Upon all, though, the "herd instinct" gradually but surely works. With the feeling that the country is in danger the unit tends to lose his individualism, and his egotistic impulses gradually but surely fall into abeyance, and the instinct of self-preservation becomes subservient to the preservation of the State.

The question of enlistment and service and what man subsequently will endure under the conditions of war rests upon the factors involved in the psychology of "suggestion" and "the crowd," combined with the still higher factor of "patriotism," which is only an extension of the former. The pictorial appeals, the more and more prevalent sight of the khaki uniform, the continual converse on war news, all acted as patent suggestions towards the one end—enlistment. The early reverses of the war stimulated the social-self to such a degree that many who had hitherto wavered joined the ranks without hesitation. At this stage much conflict ensued between the "ego" and the "ego ideal," until shame, often enhanced by remarks of friends or the presentation of a white feather, turned the scale. Many, nevertheless, remained individualistic, and rationalized extensively with regard to their seemingly unpatriotic attitude.

When enlistment did take place, mass suggestion generally became markedly felt, and the various previous fears soon dissipated and a quite altered mental attitude became manifest. Actual fear of death at this stage, if present, is but vague and fleeting, and does not recur until the front line of battle is reached. Patriotism, therefore, involves the un-

conscious subjugation of the self in favour of the great expansion of the social-self, which in time of war is enormously heightened and tends to be retained by the continual emotional influence of the army "crowd," who evince and personify a singleness of purpose—the defence of the country and the destruction of the enemy. History and mythology abound in examples of heroic patriotic acts which perforce stir us up to admiration and a desire to emulate, if only in the land of phantasy. There is no doubt but that dying for one's country is a source of joy to many, though it must be pointed out that the killing of the enemy is the more important from the utilitarian side. The psychologist F. L. Wells, in dwelling on this point, says: "Indeed, patriotic sentiment is replete with the 'death wish'; the hero regrets that he has but one life to give for his country, not that he has killed so few of his enemies. This is but another token that life is not to man the ultimately precious thing that other animals account it, but that there are strong forces in us making for its voluntary termination, which sometimes become so strong that they result in suicide. We may look upon the joy in death for group, therefore, as determined partly by a regressive seeking to escape the task of life, to be 'one with Cumberland for ever,' which tendencies reinforce each other against the individual will to live. The simple willingness to die for one's country is not a social trend so much as a regression that is rationalized in patriotic sentiment." This certainly seems an extreme view to take, but there is much truth in it. The glory attached to dying for one's country is to some extent a sentiment that is read into the minds of heroic combatants after the event, and enhanced by history and the arts, and probably enters very little into the conscious minds of soldiers in most circumstances.

Ernest Jones, in his articles on "War and Individual Psychology" appearing in the *Sociological Review*, July, 1916, says on this point from the psycho-analytic point of view that "patriotism has three sources in feelings about the self, the mother, and the father respectively. The last mentioned is probably the least important of the three, but is more prominent in some cases than in others, leading them to a patriarchal conception in which the head of the State is felt

to be the father, and the State itself the father's land. More significant is the relation towards the mother, and is indicated by the fact that a country is as a rule conceived to have the feminine gender (in the expression *la patrie* we see a fusion of both conceptions). Most important of all is the source in self-love and self-interest, when the self becomes more or less identified with one's fellow-citizens and the State is a magnified self. Psycho-analysis has shown that these three feelings are far more complex and deeply rooted than is generally supposed, and that they exert a correspondingly weighty influence on the most manifold relations of life, often in quite unsuspected ways. On the precise fate of these feelings during the stages of early mental development depends the greater part of a man's character, dispositions, including the form of his patriotism, whether aggressive, assertive, vainglorious, or the contrary; it would be tempting to compare the type of patriotism usual in different countries with the various types of 'family relationship' characteristic of each —for instance, in Germany, England, and America. . . . Whoever undertakes a psycho-analysis of men deciding to enlist in war-time will be astonished at the complexity and strength of the unavowed motives darkly impelling them and reinforcing their altruism, from the fascinating attraction of horrors to the homosexual desire to be in close relation with masses of men."

The problem of death is not as superficial as it seems, and there are scientific psychological reasons for supposing that no man really believes in his own death, and that in our unconscious mind we are all convinced of our immortality. Freud, in his "Reflections on War and Death," says: "The idea of death finds absolutely no acceptance in our impulses. This is perhaps the real secret of heroism. The rational basis of heroism is dependent upon the decision that one's life cannot be worth as much as certain abstract ideals. But I believe that instinctive or impulsive heroism is much more frequently independent of such motivation, and simply defies danger on the assurance which animated Hans, the stonecutter, a character in Anzengruber, who always said to himself, 'Nothing can happen to me.' Or that motivation only serves to clear away the hesitations which might restrain the

corresponding heroic action in the unconscious. The fear of death, which controls us more frequently than we are aware, is comparatively secondary, and is usually the outcome of the consciousness of guilt." The interesting problems connected with death will not here be considered further, and will again be discussed when we deal with the question of suicide in a later chapter.

Having started a soldier's life, fresh adaptations, mental and physical, are at once necessary to get in tune with the new environment. To the average man this is not difficult, because he is surrounded by comrades who are in the same position as he is, and slowly but surely his individuality becomes suppressed in the crowd. At the commencement, discipline is more than irksome to the soldier, and his egotistic impulses run counter to the rigid rules and life of the camp, while his enforced companionship with those who are perhaps foreign to his previous interests, and the physical discomfort he suffers in contrast to home comforts, tend to raise rebellious feelings in his breast. The curtailment of liberty both in thought and action is for a time hard to bear. This individualism in the normal newly joined recruit soon gives way as he becomes more and more a machine, and the goal idea of all to work hard, obey, and become efficient soldiers at an early date fills the mind.

There are those who, having a psychopathic make-up, or because of certain exaggerated mental factors, find it especially hard to thus adapt themselves, and in some cases no correct adaptation is ever made. It is these latter who, continuing to harbour mental conflicts, enter the fighting zone with such a mentality that they are greatly predisposed to develop neurotic or psychotic breakdowns.

Some psychologists speak of the soldier's training rendering him hyper-suggestible. Rivers* says that the process resembles closely, if it be not actually identical with, the process we call suggestion. In his opinion it is the great suggestibility that is engendered in the soldier through training that makes him liable to develop neuroses during his future career. It is true, of course, that his military actions must tend to be

* W. H. R. Rivers, "War Neurosis and Military Training," *Mental Hygiene*, October, 1918.

largely automatic, and it is indeed highly needful that his critical faculty should be conspicuous by its absence, or concerted action in time of stress and danger would be out of the question.

Presuming, then, that the soldier is now satisfactorily produced, what other psychological factors present themselves for our study? They have been made into machines, and the training has so improved their physical health that a sense of *bien-être* is felt which has been foreign to most for perhaps many years. This sense of well-being renders their instinctive impulses and desires keen and potent. Discipline, which has by now been well instilled into the soldier's nature, obviates any demonstration of such impulses while on duty, but when at leisure or on leave there is a great tendency for a reaction to set in. The intellect and the higher forms of sublimation have little place in the Service; close association tends to level the mentality of the members of the community, and in all a lower level of psychic activity is prone to manifest itself. It is true that in spare time sport of various kinds drafts off some of the excessive potential energy formed. Much of the training, especially that of bayoneting sand-bags or human effigies, must rouse latent sadistic traits which, though highly of use later when in action, may earlier revive unconscious complexes in some, and thus pave the way to pathological mental symptoms.

Problems connected with sexuality have to be faced in dealing with the wide question of the soldier's adaptation. Those who are married especially, but also those who have not been continent in sexual intercourse, find at times a tension arising from abstinence which may produce symptoms of unrest and anxiety until habit has modified such special functioning. The busy life of the soldier, if his thoughts cease to dwell on sexual matters, will mitigate natural longings, and any tension will tend to be relieved naturally in sleep. To some who are specially virile, and in whom long-continued custom has deeply ingrained a habit of relief, the enforced celibacy of military life may be hard to bear at first and productive of a neurosis. Commonly, of course, means are at hand when on pass or leave to gratify this passion, with the result that venereal disease is rampant. The sexual repres-

sion shows itself in the obscenities of conversation, sexual jests, and not uncommonly forms a central theme in dreams. Rivers states that the lurid language the soldier is apt to use is only the relatively innocent means to obtain an outlet for superfluous energy, especially that part of his energy which has tended to be repressed by discipline. His conviviality and relative freedom from restraint in certain directions has the same origin.

In time the routine of camp life, with the multifarious duties, the route marches, and the manifold training practices, pall upon the soldier, and he becomes anxious and eager to get to the theatre of active warfare and there begin that life of real adventure for which he has been so long preparing. The average civilian is specially struck and astonished that these men should show such evident desire to go where danger lurks, instead of being thankful for remaining in safety. The reason is that, under the influence of the environment of the past few months, the aggressive instinct no longer finds itself repressed, and the soldier owes his position to the fact that the State has removed certain previous inhibitions and licensed him to kill, provided it be one of the enemy. Thus the longing to gratify this impulse begins now for the first time to manifest itself.

At length the soldier with his unit goes overseas to the scene of battle. Most of us have at some time or other witnessed the lads tramping merrily onwards towards the railway-station where they will entrain for the port of embarkation. Their mental state seems mainly one of jollity. Whistling, singing old favourite music-hall ditties, and mostly with beaming faces, they march along amid the plaudits of the public. To the average outsider the sight brings wonder and to the reflective mind much food for thought. The elation thus manifested may be more superficial than it seems, and possibly is partly due in many to an emotional over-reaction to repress forebodings and banish thoughts regarding the uncertainties of the future which necessarily are so liable to rise. I believe that on such occasions conversations rarely turn to personal or domestic topics. Exceptionally there may be men who, notwithstanding the prevalent crowd emotion, feel introspective and sad. On arrival on foreign soil their

adaptation has an added strain as the exigencies of actual war render their discipline still stricter, and especially so as the front line is reached and the sound of the artillery guns becomes audible.

The hour probably soon arrives when the baptism of fire must be undergone. The earliest experiences of the trenches are purposely short for the raw troops, and here fear to some extent tends for the first time to fill each soldier's breast, and especially the fear that his courage may not be able to stand the test. Much will depend naturally upon how much hostile activity is being manifested. If the bombardment be heavy, few soldiers at this stage can be expected to remain quite normal; but it seems marvellous how quickly the human mind can adapt itself to such altered conditions of life, and within a few days a large philosophic amount of indifference to danger is shown. The soldier finds more and more that he can accurately gauge the direction and probable destination of the shells, and so they tend to lose their terror and he gains confidence at the same time. Similarly he quickly becomes accustomed to the terrible sights around him, though at first he is horror-struck at the death and mutilation of his fellows. MacCurdy* speaks of other less common reactions than fear occasionally occurring at the beginning of trench experience. One is that "of excitement accompanied even with a kind of spurious elation. The man has a tendency to make facetious remarks about the shells, to laugh at feeble witticisms, and very often feels under considerable motor tension, there being a pressing desire to do something, to do it immediately and do it hard." This is undoubtedly a phenomenon acting as a resistance to the emotion beneath, the object of which is so to fill the field of consciousness with other ideas and activities that the fear may not show itself. It is akin to the process frequently met with in ordinary everyday life of "talking past the point" when the individual in conversation wishes to repress some painful complex that is in danger of coming to the fore, and to the "press of conversation" that ensues when some subject of a specially painful nature to one of the individuals present is accidentally mentioned, and so a flood of remarks about something else is

* John T. MacCurdy, "War Neuroses," *Psychiatric Bulletin*, July, 1917.

rapidly introduced. A still more unusual but very interesting reaction, MacCurdy records, is that of "slowness or languor (which may succeed primary fear). This may be accompanied by a depressive affect or lethargy so extreme that the individual will lie down and go perforce to sleep with a pathological indifference to the danger."

Slowly, but surely, more or less perfect adaptation comes about, all fears are overcome, and the soldier becomes callous and indifferent to the suffering around him. The thought is never seriously entertained that he himself will be killed, though the chances of a wound he knows are probable, and a slight one which would be sufficient to incapacitate him, and have him sent home to "Blighty," is a frequent hope as a means of escape from the environment. Death through sheer familiarity seems to have been shorn of its terrors. But all emotional life has an ambivalent tendency, and any emotion may pass over into its opposite, which becomes the stronger because of the preceding opposite state. As Stanley Hall* says: "Fear has its fascinations, and strong, adventurous souls not only face danger when it comes, but go forth to meet it. Cowardice thus has its countervalent impulse in courage. The salt of danger is one of the great appetizers of experience. The prospect of pain acts as a tonic, and one does not need to be a hero to love to take risks and to venture in order to have. . . . Without known danger, life would be tame, insipid, asthenic. Men fight best if rightly afraid, and even weak animals, when brought to bay, fight with the energy of desperation. . . . Danger makes us more alive. We so love to strive that we come to love the fear that gives us strength for conflict." Mental breakdowns may appear now in the predisposed from emotional causes, but this will be spoken of in a later chapter.

Going "over the top" is the next great experience the soldier has to undergo, and to the novice this is a trying mental strain. There are few indeed who, having had this order for the first time, do not feel great apprehension and emotional instability. Sufficient warning is given to allow much introspection, but each man endeavours to hide his fear from his

* Stanley Hall, "A Synthetic Genetic Study of Fear." *American Journal of Psychology*, April, 1914.

comrades, and at such times especially ambivalent reactions tend to be prominent. Varied are the thoughts of different individuals, but the self-preservation complexes are mainly to the fore. The mind is clear and the attention often curiously fixed in an exaggerated form on trivial perceptions. A mild "flight of ideas" is common enough, and images of long-remote events often become very vivid. Thoughts of death itself cannot be eliminated, but each one mostly thinks that there is a good chance that he himself will be spared. In some, the conflict of opposing thoughts may lead to a slight mental confusion, but much will depend on the outward bearing of his fellow-men and on the encouragement and confidence inspired by his N.C.O.'s. and officers. In a few, a desire to be up and doing and avoid this incubation period may show itself in a restlessness and recklessness which others have to check. Nevertheless, to all mental relief is experienced when the order is heard to mount the parapet and charge. Fear then is dissipated as if by magic. All the available mental energy becomes concentrated upon the object in view. Every instinct of the brute beast is shorn of every shred of sublimation, and this total loss of all inhibition can only lead to a weird sense of elation as the impulses find full vent for their gratification. The soldier then is a member of "a pack" which is impelled forward with a single purpose—to kill as many of the enemy as possible—and he does so with savage mien and fierce imprecations. He realizes that it is the enemy's death or his, and later in the war the stories of German brutality gave him a greater zest and a fiercer passion as he bayoneted or otherwise despatched his assailant. Notwithstanding the animal level to which the human being has regressed, the lust to kill will often stop short of assailing the unprotected, the wounded, or the enemy who surrenders, provided self-preservation is not thereby forfeited.

During this acute period of activity, mental and physical, the attendant horrors of sight and sound pass unnoticed, and the death and mutilation of comrades around do not affect the individual, though in some the memories of special incidents may be keenly registered and manifest themselves in emotional disturbance at a later date. Very exceptionally the initial fear felt prior to the onset of the charge may to some

extent remain and be unaffected by the prevalent crowd emotion. Though this continuation may be dynamogenic and impel the soldier to fierce onslaughts, it may also be inhibitive and render him a weak combatant and so liable to go under. Should the company get scattered, the individual soldier, losing the sense of protection of the herd, will find his fear probably return, and the love of self-preservation may bring about flight reactions. The signs of fear are very contagious, and if they spread in the vital moments of attack a panic resulting in a disorderly retreat may occur. It is at such times that the influence of even one man, by encouragement, by gallant bearing, by the utterance of some special appeal, may avert the catastrophe and transform threatened disaster into victory. History records many stirring instances of this.

The result of the attack naturally has an effect on the mentality, so that continued success is liable to be followed by elation, indifference to discomfort and wounds, while reverses tend to depression and its attendant factors. In long-continued fighting, mental and physical exhaustion may reach their highest limit, and so much so that further activity goes on in an automatic way, the mind is dazed and confused, and any cessation of action results almost in stuporous sleep. Rest soon dissipates this condition, and the healthy soldier is again ready to carry on as well as ever. While in action, even severe wounds are often unnoticed, the perception of pain being for the time blunted or totally inhibited through the intense concentration of attention on the aggressive objective. If disabled and fallen, the soldier becomes more individualistic again, and though fear of danger may return, he is to some extent buoyed up by the reflection that his incapacity will probably render him a "Blighty" case, and that for a time at least he will be taken away from that environment of horror and death. The two opposites of hope and fear manifest themselves, and he is rendered happy or unhappy according to which emotion tends to be paramount. At such times, though, the soldier constantly shows many altruistic tendencies, and the Press during the war has given us countless stories of the self-sacrificing acts of devotion which wounded men have shown without being emotionally swayed by the heat of battle.

Once in hospital the soldier is the best of patients, and every nurse and medical officer can testify to his wonderful patience under suffering, while the average surgical ward is renowned for the cheeriness of its occupants, whose fund of humour seems to have an inexhaustible supply. It is true that in a few cases one has heard " Tommy " say he wants to return to the fighting line, but this attitude is not common. Being conscious that he has done his duty to his country so far, and looking back on so much of his past experiences with horror, he would give much not to return to the scene of warfare; but when rendered capable of fighting again, he has gone back overseas in a philosophic spirit without complaint.

The question of sexuality was spoken of during the soldier's training, and it should be noted that on active service subsequently the loss of inhibitions against the aggressive instincts seems largely to be accompanied by similar loss of inhibitions against the sexual instinct, which tends to show itself baldly in song, converse, and practice. War itself means that the moral standard of civilized communities is done away with, and it would be surprising if this change only affected the strong instinct of aggression and left unchanged and still subjugated the still more powerful instinct of sex. It is highly probable, too, that the herding together of men so closely does in many tend to lighten up latent homosexual trends, resulting perhaps in definite homosexual acts or leading to mental conflicts which in their resolution may produce abnormal mental symptoms. The point will be dealt with later in discussing psychiatric considerations. The study of the soldier psychologically brings home very forcibly the marvellous capacity for adaptation that the human psyche has. It is not surprising that many mental breakdowns have occurred in such a gigantic war, where, apart from the usual armamentarium of warfare, such horrible methods of aggression as poison gas and liquid fire, etc., have been used, but that in such circumstances so many have stood the mental strain so successfully.

CHAPTER II

MILITARY PSYCHIATRY DURING PEACE

For many evident reasons some study of mental disease as seen in armies during periods of peace is necessary in order that comparison may be made with the prevalence of mental disorders during war, and that some of the various factors entering into the production of the latter may be better evaluated in so far as they relate to the general life of a soldier and to the discipline to which he is needfully subjected. In the same way as mental disease has become more prevalent in civil populations for many years, so it has at the same time increased in the various European armies. England and the United States have shown a larger rate of admissions, due supposedly to the fact that these were voluntary armies, and that universal service gives a better average of men. Relative statistical data with the civil population must be nevertheless looked on with reserve, as cases even of the mildest type are at once recorded in the army, while in civil life only the more advanced cases are officially noted.

Until recent years mental diseases in the army in this country were studied comparatively little. Though a recruit received some examination before enlistment, the various factors concerned with a psychopathic constitution were by no means thought out, so that the potentially mentally diseased were not eliminated at the source. In the German Army the number of rejections of recruits owing to mental disease had gradually but steadily increased prior to the war, and doubtless this was due not only to an actual increase in the number of cases among the population, but also to a more careful examination and a better and earlier recognition of the condition. The incidence of mental disease in the German Army had gradually increased until it averaged 0·92 per 1,000 of strength per annum, while the French Army showed the same

steady augmentation with a final average of 0·86 per 1,000. The Russian, Austrian, and Italian military services presented very similar figures. The American Army, with its voluntary service, in 1912 showed an admission rate for psychoses as high as 1·68 per 1,000. With British troops the ratio averaged 1·4 per 1,000 from 1886 up to the South African War, since when there has been a steady decrease. The following table and chart show the exact figures:

TABLE I.—ADMISSIONS AND INVALIDS DISCHARGED FOR MENTAL DISEASES FROM 1886 TO 1908 (ALL TROOPS AT HOME AND ABROAD).

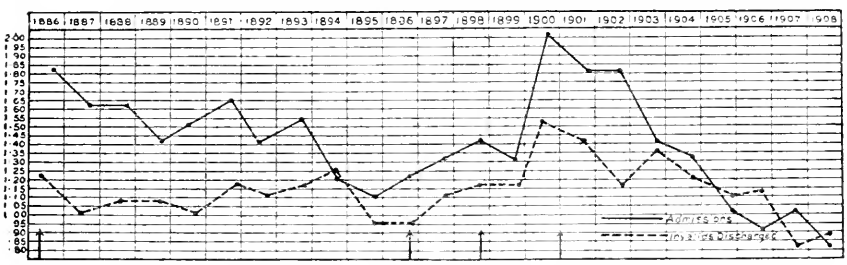
Year.	*Strength.*	*Admissions.*	*Invalids Discharged.*	RATIO PER 1,000.	
				Admissions.	*Invalids Discharged.*
1886	188,132	333	233	1·8	1·24
1887	193,627	318	192	1·6	0·99
1888	199,992	327	212	1·6	1·06
1889	198,474	281	211	1·4	1·06
1890	196,782	294	196	1·5	1·00
1891	196,104	304	233	1·6	1·14
1892	202,185	288	218	1·4	1·08
1893	205,509	302	235	1·5	1·14
1894	207,287	254	256	1·2	1·23
1895	205,879	235	197	1·1	0·96
1896	207,093	250	194	1·2	0·94
1897	201,408	268	223	1·3	1·11
1898	205,788	279	241	1·4	1·17
1899	206,023	258	234	1·3	1·13
1900	247,819	488	371	2·0	1·50
1901	228,816	401	315	1·8	1·38
1902	286,026	520	324	1·8	1·13
1903	263,888	382	350	1·4	1·33
1904	257,079	337	309	1·3	1·20
1905	248,827	246	270	1·0	1·08
1906	241,008	219	264	0·9	1·10
1907	228,605	218	185	1·0	0·81
1908	226,549	188	190	0·8	0·84

NOTE.—During the period October, 1899, to May, 1902, there were 640 admissions for mental disease amongst the troops serving in South Africa (exclusive of colonials and irregulars); these are not included in this table. What proportion of this 640 were invalided is not known.

TABLE II.—NUMBER OF CASES OF DISEASES UNDER TREATMENT DURING THE YEARS 1900 TO 1908 INCLUSIVE, SHOWN AS A PERCENTAGE.

Disease.	1900.	1901.	1902.	1903.	1904.	1905.	1906.	1907.	1908.
Idiocy ..	1·96	1·72	0·77	—	0·35	1·15	—	0·81	—
Mania ..	20·72	19·31	17·78	17·18	41·95	17·62	15·66	18·70	16·53
Melancholia	35·02	38·62	45·12	52·45	26·34	42·53	43·43	46·34	40·50
Dementia	29·69	19·10	17·97	15·95	13·59	18·01	14·64	12·19	6·61
Mental stupor ..	0·84	3·65	2·68	2·15	1·04	1·92	1·52	2·44	2·48
General paralysis of insane	1·12	2·15	1·54	1·53	0·70	1·53	1·52	0·81	1·65
Delusional insanity	10·65	15·45	14·14	10·74	16·03	17·24	23·23	18·70	32·23

CHART SHOWING ADMISSIONS PER 1,000 OF STRENGTH FOR MENTAL DISEASES IN THE ARMY AT HOME AND ABROAD.



End of Egyptian campaign.

Ashanti.

Omdurman.

South African War. 640 admissions for mental diseases amongst Imperial troops, and dealt with in South African statistics not included in above figures.

SPECIAL CHARACTERISTICS OF PREVALENT MENTAL DISORDERS.—No distinct military psychosis is found; the psychoses of army life are of the same nature as those found in civil life. The type of disease, however, varies considerably according to the military position of the patient. Officers exhibit forms of trouble usually associated with maturity (thirty to forty years), such as paralysis, arterio-sclerotic brain disease, and alcoholic psychoses, while among the privates are found more the psychoses of youth, such as dementia

præcox, manic-depressive insanity, and epilepsy. Frequently these diseases are not caused by military service, but only developed from latent conditions by later experiences. This is particularly true of mental defect and the psychopathic diathesis. As in the civil sphere, the mentally defective is encountered frequently in the army, and presents his special problems of no mean importance. Though increasingly in evidence and furnishing the largest percentage of mental anomalies, he is the one who usually attracts earliest attention in his career; and if his degree of defect is not sufficient for him to be rejected when recruited, and his duties subsequently are fairly performed, he is sure to be found sooner or later among the delinquents, as he is the most frequent type of military offender. As these defectives are not always easily recognized at the time of enlistment, a three months' probationary period which now precedes the completing of enlistment in the American Army was found desirable. It has been advocated that all men with a history of repeated offences should have their mentality thoroughly examined, as their offences usually testify simply to mental deficiency, and not to wilful misdemeanour. The term "mental deficiency" is here used in its wide sense, and includes that large indefinable class which, for want of a better designation, the modern psychiatrist would term "psychopathic inferiority." Edgar King, in an article on the military delinquent in America, states that during the years 1908 to 1913 inclusive, no less than 12 per cent. of the total number of the troops' strength terminated in military delinquency, a very large percentage being desertion. He made a study of 1,000 general prisoners as to causes of their delinquency, and found that 20 per cent. had a psychopathic constitution, 7 per cent. were constitutionally inferior, and 1·3 per cent. were morons. Schaeffer mentions the following points concerning the relations of the feeble-minded to military life:

1. They are the object of mistreatment at the hands of other soldiers.

2. They are repeatedly in conflict with discipline and military law.

3. They are notoriously intolerant of alcohol, and under its influence commit military offences.

4. They are unstable and irritable, and are especially characterized by unreasonable outbreaks of temper and assaults upon their superiors.

5. They frequently commit suicide and manifest temporary mental upsets.

It is thus patent that careful means must be taken to eliminate the mentally defective from the ranks, and as the importance of this is gradually becoming more and more recognized, measures to this end have been adopted. Later on we shall see how the British Army fared in this respect during the late war.

Dementia Præcox comes next as one of the most prevalent mental abnormalities, as one would presume, since the age of the average recruit falls well within the period that this psychosis tends to develop. Richards of America states that the percentage of cases in military life is estimated as high as 44 to 47·6, and that a large percentage of the patients with mental disease developing within a few months of enlistment belongs to this category. He points out, too, that the military surgeon must be prepared, not so much for the text-book pictures or the classical advanced cases, but for the præcox in the making, coloured by military life, by conflicts with military law, and especially by alcoholic excesses. Kraepelin (1907) said that 42 per cent. of his cases were drinkers.

Some authorities hold the opinion that many chronic alcoholic psychoses are really dementia præcox cases with an alcoholic colouring. As is well known, the præcox process may be present and produce changes in the mental life, character, and conduct of an individual months or years before the disease becomes frankly manifest. It is said that this accounts for soldiers who persist in repeated alcoholism; those who desert without apparent cause and shortly afterwards fraudulently re-enlist even though aware of the certainty of punishment; the practical failures; those unable to "get along"; the persistent sexual debauchees; and the inadequate and inefficient. Having had no experience of these cases in peace-time, I am not in a position to discuss the why and the wherefore of this special prevalence of dementia præcox from any personal knowledge, but would surmise that the soldier with

a præcox potentiality would find the environment of military life undeniably difficult to adapt to. The various emotional strains he must necessarily be subjected to and the rigorous discipline would naturally engender abnormal mental reactions in one so prone to maladapt, much more than in the freer and less restricted atmosphere of civil life. This point will be more fully discussed in a later chapter. A review of the literature on the subject points to the fact that the type of cases, when fully developed, do not differ from those we see among the civil population.

Statistics differ much according to various observers, because opinions are so variable as to which particular heading a mental disorder should be classed under. So that under *manic-depressive insanity* Edgar King states that this is a comparatively rare disease in the Service, and that "this entity is traced in the fluctuations, according to different authors, from the all-inclusive idea of Kahlbaum to the more limited one held at present." Richards says that 12½ per cent. of the admissions to the psychiatric department of the Letterman General Hospital were classed as manic-depressive psychosis. Those military surgeons who have written extensively about military psychiatry do not speak of any military peculiarities. Lieut.-Colonel Kay* gives a percentage of 40·50 per cent. melancholia and 16·53 per cent. mania in the British Army in 1908; but in his classification dementia præcox is not included, and undoubtedly these cases must have been included in the above numbers.

General Paresis is of great importance from the military psychiatric point of view, and it is the mental disease *par excellence* from which officers tend to suffer. In the European armies the percentage of all military cases averages from 6 to 7, while among officers alone it is variously estimated from 50 per cent. in the German Army to even as high as 63 per cent. with the French. It is pointed out by Richards that this does not mean a greater prevalence of syphilis among officers, but that the percentage must be higher with them than with the whole military body, as the former are generally older and more within the age period of paresis than the private, whose average age is well below

* Lieut.-Colonel Kay, "Insanity in the Army during Peace and War."

thirty years. Kay does not give in his statistics the percentage number of officers as distinct from the men who suffered from the disease, but records the percentage of all cases during the years 1900 to 1908 as varying from 0·70 to 1·65 in the British Army. He states: "Very few cases of general paralysis of the insane occur, although there is always a large amount of syphilis and its sequelæ. Our short-service system would partially explain the comparative infrequency of this particular form, but I think also the more effectual methods of treating syphilis would account for the absence of general paralysis of the insane perhaps better than any other reason." This I would greatly doubt, as there is every reason to suppose that the same effectual methods of treatment he speaks of have been used more largely in the German Service, where the percentage is so very much greater. I should be more inclined to think that the much less recorded percentage of paresis in the British forces was due more to its constant non-recognition, especially in its anomalous forms, and in all probability blood and cerebro-spinal fluid examinations were not made, without which no such diagnosis academically should be made. Richards gives 7·5 per cent. as the percentage in the American Army, and mentions points in military experience, which he says cannot be emphasized too much, where the question of incidence to the Service is of such great importance in reference to pensioning and retired pay. He quotes other authorities to show that there are other conditions which simulate this disease greatly, and which may appear in certain circumstances in non-syphilitic cases. Mention is made of a dementia following sunstroke in this category, and that the most frequent form of mental disturbance associated with trypanosomiasis is a euphoric condition resembling general paresis. These cases would evidently only relate to troops serving abroad. When I speak of this disease in relation to war conditions further mention will be made of abnormal mental states that superficially at first seemed to be cases of paresis, but which later proved to be otherwise. Syphilis at all times in the Service has been a disease of vast importance, more especially perhaps with regard to prophylaxis, but this point does not admit of discussion here. Whether one should go so far as to take the precautionary measure of preventing

the enlistment of syphilitics is very debatable, though some emphasize the importance of an intensive treatment of those in the Service and the risk run by allowing potentially insane men on duty, especially in war-time. Considering the small percentage of those who, having contracted syphilis, develop any psychosis as a sequela, and realizing that everyone to some extent is potentially insane, this emphasis must be largely withdrawn except in so far as it involves good treatment.

Toxic Psychoses (not including alcoholic), having such ætiological factors as heat, exposure, and infectious disease, were stated by Richards during the period 1899 to 1908 to be 28·6 per cent. of all cases admitted from the American Army, and in which the recovery rate was as high as 71 per cent. The question of heat as a causative factor naturally only applies to troops on duty in tropical countries, and medical officers in the Indian Service have drawn attention to mental disease from sunstroke. As we shall see when dealing with the psychoses of war, the toxins of *acute infective diseases* are answerable for definite mental disturbance, and in the American Army during the period above named a percentage of 12·6 was found to come under this heading, the main infections bringing this about being malaria, enteric fever, and dysentery. The clinical picture is, of course, the same as that seen in civil life. Kraepelin and Bonhoeffer regard a Korsakow syndrome appearing in the convalescent period as not uncommon.

Abnormal mental states due to alcohol have, of course, a great military importance, for when acute they tend so much to lead to loss of discipline and delinquencies in general. Richards gives the following facts about alcoholic indulgence in the different armies, and gives the admission rate per 1,000 men for alcoholism: "Italy in the period 1891 to 1904 did not exceed an admission rate of 0·1 per 1,000. France in the period 1891 to 1900 averaged 0·18 per 1,000 and increased rapidly to 2·4 in 1904. In America the admission rate was especially high, and in England the military offences because of alcoholism correspond more nearly with the American. England had a record in 1904 of 100 per 1,000 for minor offences, and 1,763 serious offences altogether." Steer found that "the amount of drunkenness and of military offences

because of drunkenness in the German Army were in direct relation to each other, and varied in different parts of Germany with the habits of the people as to drinking in general, and especially as to the drinking of distilled or fermented liquors. There is nothing in the military service itself to cause drinking." Chronic alcoholic mental conditions in the American Army in the period 1899 to 1908 are stated by Richards to have been probably 10·6 per cent. The relationship existing between these states and alcohol as the main *fons et origo* is a point concerning which modern psychiatrists are differing a good deal, but this question will be dealt with later when war conditions are discussed, and I can speak more from personal observation.

Paranoid states are said to be a frequent occurrence in Service cases, though no actual figures or percentages can be traced. The absence of statistics on this point is the more to be regretted as I have found this type of mental reaction very common during the late war; and it would have been interesting to compare my findings with those of peace-time, and also to have seen thereby whether certain factors which I think tend to bring them about have that value I have set on them.

Epilepsy in all European armies is a potent cause for admission to hospital and discharge from the Service. Richards gives the following statistical facts: "In the French Army, of 1,066 discharges for mental and nervous disability in 1906, epileptic cases were 418, or 39·2 per cent., of the total discharges in this class. For the period of 1895 to 1904 of all the discharges for mental disability, the percentage was about 0·8 per 1,000 of the whole French Army. Of the disability discharges in the German Navy in the period 1884 to 1901 for mental or nervous disease, the epileptic formed 4·7 per cent." However, since these figures supposedly include pure epilepsy without any psychotic complications, they are of little value for our purpose of forming any comparison with the psychoses of war.

Knowledge of much worth concerning *psychoneuroses* in military life is too little available to render it feasible to dilate upon them, even if one thought it judicious to do so. From imperfect recognition of what constitutes a psychosis, past

classifications of insanity have included undoubtedly many conditions which a modern psychiatrist would diagnose as anxiety hysteria, obsessional neurosis, etc., which, strictly speaking, should not be included among the insane, though they would come under the heading of mental diseases. Had this differentiation been academically carried out in the past, doubtless the percentages of actual insanity already quoted for the various armies would have been decidedly lessened. It is only during the past decade in England that Freudian work has stimulated many alienists to be more careful in this respect, and to look more scientifically beneath the surface of a clinical picture with a psychological eye. This looseness of diagnosis is as true during war conditions as in peace, as the abundant British literature on the subject of war neuroses has shown. "Neurasthenia" still remains as the all-embracing designation for any nervous condition or even psychosis of a mild type.

CHAPTER III

PSYCHIATRY IN WAR: GENERAL PSYCHIATRIC CONSIDERATIONS

In dealing with army psychiatry one must bear in mind that we deal to some extent with different human material than in civil life. There is largely an age limit, mainly from eighteen to forty years, and we have also men in the Service who have been through some sort of recruiting examination, and so presumably a good many mentally unfit are thus eliminated. How the recruiting has been performed from the mental point of view will be discussed in a later chapter. We have, then, a large body of the male sex only, who all have to adapt themselves to more or less the same environment and experiences. In civilian life there is a greater variety of age, individuals, and environment. From this we may deduce the fact that some types of psychoses will not be commonly met with, such as those usually met with towards or during the involutional period, and that the special circumstances involved in war may tend to bring about forms of mental reaction not so frequently seen in ordinary life.

One can readily understand that the mere fact of removing an individual from his civilian occupation, taking him out of an existence where, within wide limits, he had great liberty of thought and action, and placing him in so different an environment in which he finds an unaccustomed iron discipline whereby he has his freedom at once almost entirely curtailed, tends by itself to engender mental reactions which may be abnormal, and especially so in those who have a psychopathic constitution. Before the Commission which sat to inquire into the recruiting problem, in the evidence given by the military authorities, the opinion was freely expressed that if a man was fit enough to do any form of work in civil life, he was fit to do that work in the army. Never was there a

greater fallacy. Large numbers of cases which have been returned from overseas with psychopathic symptoms freely illustrate the falsity of this statement. The mental factor has not had anything like the consideration it should have received, and this lack of seeing the great importance of such a factor in relation to military service is seen everywhere in our social life, where mental fitness for the various avocations in industrial and professional spheres is to a great extent totally ignored. One can formulate few rules on such a point. Every case must be treated on its individual merits. If there be any evidence of mental maladaptation in civil life, how much greater will the probability be of such under the complex conditions of military life, and still more so in actual warfare!

One can readily understand that in discussing the question of the ætiology of war psychoses one has to take a very broad outlook, for the various factors which may predispose and be directly or indirectly causative are manifold and complex. During the years of modern medicine, the soldiers taking part in active warfare have been more or less trained and picked men, and for the first time the civilian population has in this great European conflagration been suddenly called upon to fill the ranks of large armies. The conditions of warfare have, too, suddenly changed so much. Enormously high explosives, poisoned gases, and liquid fire have been added to the army's armamentarium, while bombing from the air and the peculiar methods of trench strategy have added so greatly to the mental and physical strain of the combatants. Except for some psychiatric publications by Russia after the Russo-Japanese War, the only literature on military psychoses has previously treated of the findings in times of peace. Richards tells us that it was in the Russo-Japanese War that for the first time in the history of the world mental diseases were separately cared for by specialists from the firing line back to the home country.

Weygandt* states there is no special war psychosis, but war is very liable to fan into a flame a latent predisposition to epilepsy, hysteria, slight imbecility, and manic-depressive or

* W. Weygandt, "Psychiatry in the Field," *Med. Klin.*, Berlin, September, 1914.

catatonic attacks, or syphilitic, brain, or spinal cord trouble. He cites figures showing that psychoses developed in 0·54 per 1,000 of the German troops during the Franco-Prussian War, in 2·7 per 1,000 of the United States troops in the Cuban War, in 2·6 per 1,000 in the British during the Boer War, and in 2 per 1,000 in the Russian troops during the war with Japan; while the records show only 0·33 per 1,000 among the Bulgarian troops in the late Balkan campaigns, 0·25 in the Montenegro troops and also in the Serbian troops, and 0·097 per 1,000 among the Grecian troops. He ascribes the difference between the Russian and the Balkan figures to the liquor-drinking among the Russians. He does not offer any explanation, however, for the large numbers among the German expedition corps in South-West Africa—4·95 per 1,000; including cases of epilepsy and hysteria. 8·28 per 1,000 of the troops were affected. Meyer* mentions that statistics of the Spanish-American and the Boer Wars show at first a very slight, followed by a much greater, increase in the number of mental cases, probably due to the fact that the hardships of war increased with each succeeding year. During the Russo-Japanese War the proportion was 2 mental cases for each 1,000 men of the army, the proportion in civil life being 4 per 1,000. Alcoholism was the most pronounced ætiological factor. A Japanese observer states that typhoid fever and beri-beri were also primary causes of mental trouble.

In taking a survey of the many factors which take part in the causation of the psychoses of war, much will depend on what our fundamental view is on the subject of the ætiology of psychoses in general. Those who take up an essentially materialistic standpoint see the essential factors in the toxins produced by disease and exhaustion, in the inhalations of noxious gases, in the effects of direct or indirect concussion brought about by high explosives. Others believe that the main bulk of the psychoses are psychogenic in origin, and look to mental conflict as the great factor to study. I hold this latter view-point, and shall endeavour to show that this is as true in the psychoses of war as it is of peace.

It would be ideal to devote a chapter to the psychology

* E. Meyer, "Psychoses and Neuroses in the Army during the War," *Deutsche med. Wochen.*, December, 1914.

of war itself, because one would thereby see the easier how mental conflicts can readily arise when latent instincts are so strenuously aroused and at times join issue with later sublimations. For many reasons such a chapter is not feasible here, but some useful points might briefly be dwelt on. Modern psychology can throw much light on the problems of war. In our development from the child to the adult we pass through a phylogenetic scale, and we are born with these aggressive instincts, which are so useful in times of war, and without which men would and could not fight; but by the educative influences of civilization these are largely repressed, and to some extent drafted off—"sublimated"—into useful social channels. In times of war the combatants tend to regress to these primitive instincts, and pent-up emotions find vent. In our study of the neuroses and psychoses we see the same phenomenon occurring under another guise. The main effect of civilization upon our psyche, which involves the subjugation of these so-called animal instincts, is undone, but by sanction of the State, and it is because man thus tends to find pleasure in the realization of his deeper unconscious nature that he so freely volunteers to join the Service ranks. We see, then, that in the circumstances of war the soldier's mentality in many ways undergoes a profound change, and the change is heightened and perpetuated by herd suggestion; but there is always the liability for sublimation to return, for herd suggestion to fail, and in such cases mental conflicts necessarily ensue between individual feelings of an altruistic nature which lessen the fighting capacity and the aggressive instinct. Conflicts of a less biological and more personal nature, too, will be engendered, and these will be discussed elsewhere.

In considering the factors tending to bring about a mental breakdown one must first bear in mind the point I have already alluded to—that is, that the necessary abnegation of free thought and conduct, combined with the fact of becoming subject to an unaccustomed iron discipline, is sufficient, especially in the psychopathically predisposed, to produce mental reactions of an unhealthy type. Such reactions must be helped on, too, to a great extent by associated factors—the leaving of home and those near and dear to them, and

in many cases dependent on them, the blighting of ambitious hopes in civil life, the fear of financial ruin, the loss of business, and maybe the dread of future incapacity or loss of life. Doubtless the herd instinct with the average man tends to overwhelm these incapacitating thoughts and feelings, and the "crowd emotion" gradually but surely begins to fill him with martial and patriotic sentiments, so that, before long, he is straining hard to be an efficient soldier and even longing to come to grip with the foe. Nevertheless, many experiences may render him individualistic again, and it is then that mental conflicts are set up which in the predisposed may result in psychopathic reactions. Should he have had previous mental breakdowns, his outlook in any circumstances is worse, but he is usually ashamed to mention the fact at the time of medical examination, and even when known to the authorities the fact has been often, if not usually, ignored. I have had a man under my care whose history sheet was marked under the heading of "Slight defect, but not sufficient to cause rejection"—two previous attacks of insanity! That the general trend of feeling in the minds of the combatants has an effect on the predisposition to psychotic disturbance is shown by the statement of Neymann*, who says that during the early period of the war—in fact, until the Battle of the Marne—not a single mental case was received at the hospital where he was stationed. This, he thinks, was probably due partly to the attitude of the German Army, buoyantly sure of speedy victory, for when the fighting changed from open to trench warfare the whole situation was changed.

In nearly all the literature that has been devoted to the discussion of the war psychoses there has been little evidence of any attempt to discriminate the various ætiological factors that might bring them about. The neuroses have been dealt with in a far more satisfactory manner, and the best qualified investigators have become mostly in accord as to their psychogenic origin, and have swept away as useless and unscientific the theory that concussion and the inhalation of noxious gases have any direct relationship with their produc-

* Clarence A. Neymann, "Some Experiences in the German Red Cross," *Mental Hygiene*, July, 1917.

tion. Psychiatric authors have usually been content with some such similar explanation, or have in a vague way spoken of the effects of emotion, exhaustion, or "stress and strain." Stress and strain are said to account for much, but without going into detail of what they involve. Little, if anything, is thereby added to our pathological knowledge. Such a term supposedly comprises mainly the factors of mental and physical exhaustion, and perhaps also climatic conditions and hardship, but it is held here that these would not produce mental disturbances without other factors being involved. There is ample evidence to show that this is so.

In my opinion the so-called "*exhaustion psychosis*" requires much more pathological investigation. Intense physical exhaustion alone can produce no psychosis. Mr. Philip Gibbs, the war correspondent of the *Daily Chronicle*, wrote on April 3, 1918, concerning men who had fought for six days and nights: "They were almost tired to death, and when called on to make one last effort after six days and nights of fighting and marching, many of them staggered up like men who had been chloroformed, with dazed eyes and drawn faces, speechless, deaf to words spoken to them, blind to the menace about them, seemingly at the last gasp of strength. Towards the end of this fighting they had a drunken craving for sleep, and slept standing with their heads falling against the parapet. In body and brain those men of ours were tired to the point of death. They felt like old, old men, yet after a few days' rest they were young and fresh. It was almost impossible to believe they were the same men. They had washed off the dirt of battle and shaved, the tiredness had gone out of their eyes, and their youth had come back to them."

This graphic description pictures very vividly how the extreme limit of exhaustion had been reached, and yet with a few days' rest all was well. If intense exhaustion produces chemical toxins which, acting upon the nervous system, is said to bring about a confusional psychotic state, how can we explain the fact that the experiences written above have been quite frequent, and yet these men have retained their mental health? It is very possible that some lowering of resistance may be left which may predispose the men to a later breakdown, but it is very doubtful if even that

would occur without some definite psychogenic factor. Farquhar Buzzard*, in an article on "Warfare on the Brain," mentions the not uncommon symptoms of restlessness, insomnia, irritability, diminished attention, etc., which have resulted from exhaustion in front-line soldiers, and he shows how this condition soon subsides if rest is promptly given. These fatigue states are very distinct from actual psychoses, even if they are allowed to become chronic. Abnormal nervous functioning, though frequent from exhaustion, must be distinguished from psychological abnormalities, which require the presence of other ætiological factors. It is stated that the effects of fatigue among Serbian prisoners were specially marked, and yet the so-called exhaustion psychoses were conspicuous by their absence.

Clarence Farrar†, from his experience among the Canadian forces, deals with this question so adequately that I will quote him: "It turns out that we have probably been making too free with the diagnosis, exhaustion psychosis, thus furnishing another example of the perennial error of drawing the conclusion of casual relationship where the thing actually observed is only a coincidental association. Many of the earlier writers on the psychopathology of the present war, taking as a starting-point the universally recognized symptoms of acute physical and mental fatigue, have gone on to the description of a considerable variety of neurotic and psychotic states, depressive effect, clouding, states of anxiety, delirious excitement, dream disorders, hallucinatory complexes, etc., in all of which the tendency has been to assign a first-rate ætiologic importance to the factor of exhaustion. That it has its influence in many cases no one could disprove, and no one would perhaps deny. But the note that Birnbaum sounded in his first review of the literature in the spring of 1915 was timely. He pointed out that pictures similar to the assumed exhaustion states frequently occur, solely in consequence of psychic shock, as symptoms of frank psychogenetic disorders, and that there is much to suggest the purely psychic origin of these disturbances in war. The suspicion

* Farquhar Buzzard, "Warfare on the Brain," *Lancet*, December 30, 1916.

† Clarence B. Farrar, "War and Neuroses, with Some Observations of Canadian Expeditionary Force," *American Journal of Insanity*, April, 1917.

is at least strong that in conditions of this sort, developing on a basis of exhaustion, a psychogenic factor often exercises a determining influence, and contributes to the symptom picture its special character, which would be lacking in cases of *surmenage* uncomplicated by psychogenic causes or shock."

Continued war experience has only served to undermine more and more the position of the so-called exhaustion psychoses in psychiatric nosology. Bonhoeffer* was unable to find evidence of their occurrence as the result of the conditions of warfare. Even the pathogenic significance of exhaustion in the development of other types of nervous disorder he considers open to question. He is unable to corroborate, for example, the findings of Weygandt that the incubation period of dementia paralytica is shortened and the course more rapid under the influence of war strain. On the other hand, the effect of this factor on the course of physical disease is universally recognized. Bonhoeffer sums up the situation thus: "A collective survey of war observation demonstrates the great power of resistance of the healthy brain, and the insignificance of both exhaustion and emotional factors in the development of actual mental diseases." Aschaffenburg agrees with Bonhoeffer, and goes a step farther, dealing perhaps the last blow to the exhaustion psychoses. He denies any ætiologic importance in the psychoses to the exhaustion element, and declares he has seen no case (and his experience dates from the beginning of the war) in which any psychic disturbance worth mentioning had resulted from exhaustion. These statements of Aschaffenburg are the more significant because of the fact that he previously devoted much attention to just the conditions whose right to a name he now disputes. These earlier studies he admits quite overstepped the mark, and he is willing in the light of his military experience to consign them to oblivion.

I have quoted at length because I am in such absolute agreement, and am gratified to know that I share these opinions with such authoritative observers. It is certain that the experiences of this war have shown that exhaustion is not a factor to be reckoned with in the production of psychoses. Though

* "War Experience on the Ætiology of Psychopathic States," *Allgem. Zeitsch. f. Psych.*, ref.; *Zeitsch. f. d. ges. Neurol. u. Psych.*, ref., xiii. 3, 1916.

Crile* has shown in his laboratory experiments and clinical observations that identical brain-cell changes and similar outward manifestations are shown in the exhaustion produced by prolonged physical exertion, intense emotion, insomnia, certain toxæmias, and intense fear, he only brings evidence of organic changes, and in no way confirms the idea that a psychopathic state must necessarily ensue. For some reason or other the diagnosis of exhaustion psychosis has been added of late to the official nomenclature of diseases. This may have been harmful, in my opinion, in that it may have led many to use this term heedlessly, and encouraged others not to look farther for deeper and more important factors. It has been interesting to note the different types of cases that have come to me from overseas with this label attached.

The question of *climate* calls for no special mention in the Western sphere of war, as it was only part and parcel of the general hardship that a soldier had to undergo; but in Salonika, Egypt, Palestine, and Mesopotamia there have been special climatic conditions which have been contributory to mental breakdowns, and special diseases in these cases have had a large share in increasing the incidence of psychoses. Among the former, heat-stroke and sunstroke have been often quoted by medical officers as productive of mental disorder, which has been often of a confusional type. Not having been able to study such cases for a sufficient length of time, I must hesitate to dogmatize as to cause and effect; but I feel very sceptical as to any direct causation, and believe that these factors only tend to lower mental resistance and inhibitions in the same way as may traumata and various somatic illnesses. Overbeck-Wright† states he thinks it is an established fact that neuroses and psychoses are more common among Europeans and their descendants in hot climates, and that in a way the climate may be said to be an essential factor in their development. He superficially ascribes this presumed fact to the mode of living—*i.e.*, eating an abundant flesh diet, imbibing alcoholic beverages freely, and displaying an energy in the pursuit both of business and pleasure which

* G. W. Crile, "The Origin and Nature of the Emotions" (W. B. Saunders Co., Philadelphia, 1915).

† A. W. Overbeck-Wright, "Mental Derangements in India," 1912.

is in strong contrast to the placidity of the native. As a result of this, the individual sooner or later falls a victim to dyspepsia, and when this condition becomes chronic he is naturally more liable to metabolic or bacterial toxæmias and a train of nervous symptoms which may pursue him until death. Would that explanations of psychopathic disturbances were so simple! Many of my cases with various psychopathic symptoms blamed the heat largely for their breakdown, and whether this was a rationalization or not I am not in a position to say, but I am inclined to place heat in the same category as exhaustion—that is, as only being contributory. Indian psychiatrists state that, though sunstroke is perhaps the commonest reason given by relatives for an attack of insanity, in the vast majority of cases such a reason needs qualification. Three types are described: one varying from complete dementia up to little more than a change of temperament and a liability to intense fits of passion; a second form characterized by changes practically limited to only one of the mental functions, such as pronounced amnesia or a moral change; and a third, a post-febrile psychosis, showing excitement, restlessness, with hallucinations and persecutory delusions.

Acute illnesses were predisposing and contributory as well. On the Western Front this factor was negligible, but in the East malaria and dysentery both acted as determiners of much mental disorder. Malaria was a factor in many ways. A large number of cases suffered from pyrexial or hyperpyrexial deliria of a more or less temporary nature, but sometimes leaving mental sequelæ of various types. Others showed a definite infective form which left the patient in a mild confusional state for some length of time. The malarial toxin was responsible for the production of many amnesic states, some of them evincing symptoms akin to Korsakow's syndrome, while in other cases the disease was sufficient in the predisposed to so lower mental inhibitions that various psychopathic disorders showed themselves. In recurrent and severe cases the debilitated physical state lowered the resistance to mental disorder, and in a few epileptiform convulsions were found as complications. It is probable, too, that definite organic nervous changes were at times caused by

severe malaria with consequent mental symptoms. Overbeck-Wright states from his experience in India that "malaria, by the action of its toxins, as well as by the debility it produces, may be responsible for an attack of insanity. In the febrile stage I have seen patients who were at first in a condition of delirium gradually pass into a condition of maniacal excitement with hallucinations, which lasted for a few days to a week or more after all fever had passed off." He also mentions cases of patients who, after a long chronic course of fever, passed into a semi-stuporous condition, and wandered away many miles from their home, with a subsequent complete amnesia for the period. Dysentery stands much in the same category, and D. K. Henderson* has published some interesting cases of memory disorders caused by the toxic-exhaustive states of this disease. It seems that there is much scope for some original research on the mental complications and sequelæ of these diseases, but malaria especially.

Physical traumata, such as head wounds and concussion, may lead to the exhibition of mental symptoms through definite interference with or destruction of cerebral tissue, and following on such injuries many anomalous states tend to occur. Fugues, amnesias, character changes, and convulsive attacks were those mainly seen. We know comparatively little of the pathology of these post-traumatic states, but it is probable that the loss of inhibition brought about by the trauma, thereby permitting latent tendencies and instinctive trends to gain control, is the basis of those cases where an organic change is not in evidence. Where a cerebral lesion has been occasioned either through a simple or compound fracture of the skull we may see varying degrees of mental dulness, from a mere obfuscation to a deep stupor, and perhaps complicated with confusional delusions. Much depends often upon the region of the brain involved, for, as is well known, even extensive lesions of the frontal region may be unprovocative of much psychic abnormality. Special mental symptoms may develop subsequently in the train of certain cerebral complications; cases of *concussio cerebri* with consequent coma, confusion, and dream states with a later amnesia

* D. K. Henderson, "War Psychoses," *Review of Neurology and Psychiatry*, May to June, 1918.

have not been uncommon, but of course have not frequently found their way into mental wards. States of anxiety hysteria following upon high-explosive traumata were at one time supposed to be mainly due to the effect of concussion by those whose materialistic outlook prevented them from seeing their psychic origin. Hence the origin of the term "shell shock." MacCurdy* has demonstrated very ably the psychogenic basis of these states, and most trained observers have amply confirmed his ideas. This question will be more fully debated in the chapter devoted to the neuroses.

Many authorities regard pre-existing *syphilis* as a marked predisposing cause of nervous and mental disease in times of war and strain. I cannot personally say whether this is so or not, and the point is a very difficult one to decide. The Wassermann test is not always to be trusted except undertaken by very skilled hands, and even if the result of the test in a patient be positive, how can one show that this has any real relationship to the psychosis ?

The question of *alcohol* is of more importance, and also very debatable. Although I can trace only a comparatively small number of cases to its direct influence, there are some who take a very opposite view. Lepine† makes the astounding statement that alcohol was the primary and sole cause in one-third of his cases, and more than half, perhaps two-thirds, were influenced by it ! His data were based upon the observation of 6,000 cases, but it is difficult to see how he could come to such a conclusion. He likens the rôle that alcohol has played in this war to that of malarial disease in the pathology of certain countries, and in graphic terms makes a tirade against it, as he describes the manifold physical and mental symptoms which have followed its consumption. Charon‡ also states that acute alcoholism in the French Army was the principal and immediate cause of psychic illness in combatants. In his own words: "Mais ce qui ressort dans toute sa gravité et toute sa laideur c'est la tare honteuse de l'alcoolisme, qu'on trouve comme cause efficiente

* John T. MacCurdy, "War Neuroses," *Psychiatric Bulletin*, July, 1917.

† Jean Lepine, "Troubles mentaux de la Guerre" (Paris: Masson, 1917).

‡ René Charon, "Psychopathologie de Guerre," *Progrès Médicale*, June, 1915.

indiscutable dans plus de 32 per cent. des cas. L'alcoolisme aigu étant bien la cause la plus fréquente et la plus immédiate de la confusion mentale, il ne faut point s'étonner de la prédominance énorme de toutes les variétés confusionelles dans les manifestations psychopathiques presentées par nos malades."

If the observations and deductions of these workers are in any way true, and they have not been led away by a conscious or unconscious prejudice against alcohol, I can safely say that the cases met with in the British Army have been different. The result of my statistical work in this direction will be noted later. In the Russo-Japanese War the percentage was very high, according to Gerver, and accounted for one-third of all the psychoses. He claims, however, that in the last Russian campaign the number of psychoses was comparatively small, and that the decreased rate was due to the total absence of alcoholism, not a single case of alcoholic insanity having occurred. Without knowing more of the conditions under which the Russian soldiers were placed, one cannot draw any hard-and-fast deductions, but the facts as stated are worth recording.

From my point of view, the question of alcohol in the causation of mental disease requires much reconsideration. Apart from the acute intoxications and those chronic states induced by many years of excessive imbibing, thereby producing a demential condition, I can but regard alcohol as only a contributory factor, working with and aiding mental conflict. The drug is so often taken as a narcotic to endeavour to drown a conflict which is either conscious or in danger of becoming so. Alcohol tends to remove inhibitions, aids mental regression, and in the end psychological mechanisms are set in action which mostly bring about the result of having saved the individual mental pain. The effects are compensatory. What would have happened if the alcohol had not been taken? Ferenczi* says: "The one-sided agitation of temperance reformers tries to veil the fact that in the large majority of cases alcoholism is not the cause of neuroses, but the result of them, and a calamitous one. Both individual and social

* Ferenczi, "Contributions to Psycho-Analysis," English translation by Ernest Jones (Richard Badger, 1916).

alcoholism can be cured only by the help of psycho-analysis, which discloses the causes of the 'flight into narcosis' and neutralizes them. The eradication of alcoholism only signifies an improvement in hygiene. When alcohol is withdrawn, there remain at the disposal of the psyche numerous other paths to the 'flight into disease.' And when, then, psychoneurotics suffer from anxiety hysteria or dementia præcox instead of from alcoholism, one regrets the enormous expenditure of energy that has been applied against alcoholism, but in the wrong place."

There is much to be said in favour of this view, which to the average reader will seem an extreme standpoint. In all discussions on alcoholism from the social side the psychological view-point, though of supreme importance, is conspicuous by its absence. Now that psychology is fast becoming essentially humanistic, we may look forward at an early date for its principles to be applied and sought in the solution of this vital social problem. In more or less superficial statistical work it is difficult to make sure as to the absence or not of the alcoholic factor, but in my experience in the war psychoses it is not a glaring one, and, when present, is so constantly found not to have been a main one. Precisely the same syndrome may be met, with or without alcohol as an adjuvant. It is hardly appropriate here to dilate more fully upon this interesting problem. The topic will be touched on again in dealing with the clinical material itself.

There only remains to discuss the question of *mental conflict* as the last but most important ætiological factor in the production of the war psychoses. Now that modern psychiatrists are more and more studying the psychology of mental diseases they are tending *pari passu* to find mental conflict as the *fons et origo* of the psychoses. Of course, I do not refer to those psychoses which patently have their origin in organic nervous disease, those which are due to endogenous and exogenous toxins, and those which are congenitally developmental. The majority of mental disorders, though, do not come under these headings, such as the cases of dementia præcox, manic-depressive insanity, paranoia and paranoid states, certain of the epilepsies, and many anomalous abnormal states which cannot be easily

placed under any special heading. Those which form the large bulk of the psychoses both in civil life and in active military service, which are in loose phraseology termed "functional," are mainly psychogenetic or, using a wider and perhaps better term, biogenetic. More than ever is it patent in the psychoses of war that the factor for study is the question of adjustment to environment which the soldier is consciously and unconsciously always endeavouring to bring about. Man possesses many levels of reaction which recapitulate his development from lowlier forms, and it is in the successful integrating of these that correct adjustment results. In the genetic approach to such questions White* so clearly and interestingly deals with these various levels, which in the process of evolution have progressed from the lowest physical reaction to the physico-chemical, on to the reflex level of the central nervous system, up to the culmination of the psychological level which later takes on social values. Socially efficient conduct is the result of a correct integration of all these reaction levels, though it is at the psychological and social level that the main perversion of functioning occurs in psychotic states. This, though, must involve to some extent an upsetting of the other lower reactions, and hence endocrine disturbances and somatic changes which so many observers shallowly regard as primary instead of secondary.

It is not within my province here to dilate at any length upon that which should more appropriately be discussed in works on general psychiatry. The psychological mechanisms involved in the production of the psychoses, the distortions and disguises which those same mechanisms have brought about, and the end results in more or less clinical types have been much studied and formulated in dementia præcox, manic-depressive insanity, and paranoiac states. Further research now reveals psychogenic factors in many of the so-called alcoholic psychoses, in epilepsy, hallucinatory deliriums, and prison psychoses. We understand now to some extent that the aim of these psychological mechanisms is constructive, and that the patients thereby have defended themselves

* William White, "Mechanisms of Character Formation," chap. ii. (Macmillan, 1916).

against internal warfare, have built a world of their own in which they feel they can live, and have in many instances obviated mental pain and self-reproach, and so gained their compensations. In active service the symptoms arise mainly as a defence against external situations and internal warfare. Francis Shockley,* in speaking of unconscious defence reactions, says truly: "Certain psychopathological conditions, when analyzed, are found to be the logical outgrowth of environmental experiences which are unpleasant to the ego. The censor, in order to keep these from the conscious memory, develops certain unconscious defence reactions. Many varieties of defences are formed. These are all similar in that they serve a common end. The resulting symptom depends for its characteristics on the degree to which one's biological functions are distorted, and on the emotional value of the inciting cause." The psychical energy, when not directed in one direction, must go another, and when withdrawn from the realities of battle there is at once a liability to introversion, introspection, and revival of past memories and phantasies, with the production of morbidity and mental conflict. In warfare we should not be surprised to find great opportunities for mental conflicts. The battle within between the highest desire to follow the dictates of duty and honour, and the individualistic wish for safety and to be out of it all, is a conflict that must occur at any rate now and again to almost every combatant, though this self-preservation conflict is more productive of psychoneurotic symptoms than psychotic ones. News from home of a disturbing nature, the failure to get leave, the separation of loved ones, and the unfaithfulness of wives cause worries that one hears of in case after case of mental disorder. Exhaustion and indisposition rendering the sufferer less able to perform his work efficiently tends to bring about morbid feelings of incompetency, unworthiness, and impotency. The various factors of stress, strain, traumata, and illness may so lessen inhibitions that old conflicts are apt to be aroused with perhaps untoward mental results. Enforced sexual abstinence in some causes anxiety, promiscuous intercourse, self-reproach, and I believe

* Francis M. Shockley, "Clinical Cases exhibiting Unconscious Defence Mechanisms," *Psycho-analytic Review*, vol. iii., No. 2, April, 1916.

that the sole male companionship in many lights up a latent homosexuality which, though perhaps never becoming conscious, produces a mental conflict, and, maybe, a paranoid state.

Of course, mental conflicts can produce no psychosis if resolution takes place normally, but through repression and abnormal resolution havoc may be wrought, and especially in those whose mental soil is fertile. In cases of amnesia, amnesic fugues, and many stupors the defence mechanisms are evident, but these will be spoken of in their appropriate place. I am convinced that in a large number of instances alcohol is freely taken to narcotize these conflicts, which might or might not have produced psychopathic symptoms without its use. As I have previously stated, even in those abnormal mental states which follow upon physical illness, trauma, or exhaustion there is good reason for believing that a psychogenic factor is present and brought to the fore by a failure of repression caused by the temporary loss of inhibition.

That the superficially presumed causes of stress and strain of war had great relationship with the production of psychoses is vetoed by the large number of admissions I received from overseas after the armistice had been declared and all hostilities had long ceased. It is interesting to note that the psychoneurotic disturbances very soon almost entirely ceased when active warfare stopped, whereas the psychoses continued to develop. This only confirms the modern idea that the war neuroses were based upon self-preservation conflicts, whereas the psychoses developed from other mental conflicts the factors of which were still to a large extent operative.

The fact that the emotions have intimate relationship with the internal secretions has led many to regard these latter as in some way causative of psychopathic states. These secretions may certainly at times bring about secondary results and aid in perpetuating a lowered threshold of consciousness to stimuli, but they have no ætiological importance. As Cannon* says: "Intense emotions in war may cause much adrenalism, which, if not worked off, may have injurious effects; similarly with thyroidism."

* W. B. Cannon, "Bodily Changes in Pain, Hunger, Fear, and Rage" (New York: D. Appleton and Co., 1915).

CHAPTER IV

THE MILITARY ORGANIZATION FOR CARE AND TREATMENT

At the outbreak of the late European War there was little foresight shown or preparations made for a large influx of mental cases, which a small amount of reflection would have adumbrated. It is true that at the onset of war only small numbers of British troops were engaged in conflict as compared with the vast army later recruited from civilian life, but in proportion the cases of mental disorder were soon large, and no fitting organization was in existence for their disposal and care. On undertaking the offensive against such a powerful enemy as Germany it is reasonable to excuse the military authorities for not at once organizing arrangements for the care of every variety of medical disease, and the seriousness of the early reverses and the general situation naturally strained the energies of the military to such an extent that the important factor of the mentally afflicted could hardly be expected to receive its fair share of attention. The exact numbers that had to be dealt with in these early days and in subsequent years can be seen if the reader refers to the chart opposite p. 50, showing the admission rates. These numbers might, of course, have been very largely reduced had they been more eliminated at the source by seeing that recruiting boards paid some attention to the mental factor, and by having the men again examined by mental specialists prior to going overseas. This point, though, will be dwelt on in a later chapter.

From the very commencement of hostilities every Expeditionary Force officer, N.C.O., or private who evinced any mental symptoms which could reasonably be thought to be in any way psychotic was sent to " D " Block, Netley, the Mental Division of the Royal Victoria Hospital. Convoys of such cases reached there from France, Belgium, Italy, Salonika,

Palestine, Mesopotamia, Egypt, and India. Some very few came from Russia, since Great Britain sent a force there to the Murman coast, and a few others have been repatriated prisoners of war. At one time German prisoners of war who had mental disorders were admitted to Netley as well, but this procedure was so obviously undesirable that they were later sent to other institutions. At first the cases that were admitted to "D" Block were dealt with according to the ordinary King's Regulations, which necessitated discharge from the army because of insanity and transference to their district asylum, where their status was no different from the other inmates. For manifold and patent reasons such a procedure became out of the question for continuation, so that thereupon an organization was commenced for the care, transport, disposition, and treatment of mental cases, which as time went on had to be extended and altered until it finally became as near the ideal as circumstances would permit.

At an early stage it was thought to be judicious and equitable not to send the cases to ordinary civil asylums, but to equip special War Mental Hospitals where all army psychotic cases should eventually be housed and treated until a certain period had elapsed, during which time the medical staff could formulate a safe opinion as to the chronicity of the disease and whether the cases necessitated continued segregation. This period was first fixed at twelve months, and it was not until the end of that time that any cases requiring further hospital care were certified as insane and transferred to a civil asylum. Even this was not done if the soldier's friends would take the responsibility of his care, provided that the disorder did not involve danger to others or the patient himself. So many, though by no means recovered, were so much improved that institutional care was not needed.* Later, through pressure of accommodation and the large increased influx of cases, the period of treatment in a War Mental Hospital was shortened to nine months, and, considering all the circumstances, I think that this was a wise step, as in such a space of time there was ample opportunity for the medical officers to estimate the gravity of the psychotic symptoms and form a fair prognosis.

* See Tables II. and III., Chapter V.

In January, 1915, the pressure began to assume such an important aspect that the War Office asked the co-operation of the Board of Control to arrange for a large increase of accommodation. This entailed a vast amount of work and organization, as various civil asylums one after another were converted into War Mental Hospitals*, for the large numbers of civil cases had to be found accommodation elsewhere. This involved unavoidable overcrowding in many institutions. The number of War Hospitals found necessary increased as time went on, until in 1918 there were 4,470 beds available in the British Isles for mental cases. These War Mental Hospitals were: The County of Middlesex. Napsbury (350 beds); Lord Derby's War Hospital, Warrington (1,000 beds); Welsh Metropolitan War Hospital, Cardiff (450 beds); Dykebar War Hospital, Paisley (500 beds), and Auxiliary Hospital at Crookston (350 beds); Murthly War Hospital, Murthly, Perth (380 beds); Northumberland War Hospital, Newcastle (100 beds); Notts County War Hospital, Nottingham (540 beds). From the above Irish cases could be transferred to Belfast War Hospital (500 beds) and Dublin War Hospital (300 beds).

These hospitals, which I had the privilege of visiting, were so equipped that the mentally disordered soldier could not possibly with any reason complain of his position. In many, beside the male attendant staff in the wards, nurses were also on duty, and I am assured to the great benefit of their patients. Great prejudice has always hitherto existed to the employment of female nurses in male wards, but I am convinced that no adequate reason exists for such a feeling, and the majority of those who have experimented in this way have subsequently been convinced of the good that ensues. The female nurse will so often not only have greater kindliness of heart and sympathy for the cases under her care, but frequently evinces a tact and judgment that the male attendant lacks. For attendance on those who have physical illnesses in infirmary wards her usefulness is patent. The patient, too, will tend to exert what self-control he may possess to restrain

* The dropping of the word "asylum" was specially undertaken to obviate, if possible, the stigma that might be felt to attach to the name, which stigma does exist, rightly or wrongly.

himself from the use of obscene language and the perpetration of antisocial acts he might otherwise evince. Much depends, of course, upon the type of nurse engaged, but with proper selection and judgment the employment of such will enhance the working of a mental hospital, and I trust in the near future to see this idea much furthered. That unnecessary violence in the handling of recalcitrant patients is lessened when female attendants are on duty is certain.

As Dr. Thomas Salmon, the Medical Director of the National Committee for Mental Hygiene, U.S.A., says: "One outcome of the conversion of the institutions seems likely to be the employment of female nurses in men's wards in civil institutions in England. No one who has seen the success with which this is done in the United States, and its rapid extension as a result of its efficiency and the increasing difficulty of securing male attendants, will regret it."

In these War Mental Hospitals not only are convalescent wards provided where cases can be placed as they near recovery, but all suitable cases have their parole, which is seldom abused. Thereby the feeling of restraint is not only lessened, but there is here, too, the chance of rubbing shoulders at times with the outside world, and thus furthering gradual adaptation to ordinary life. When the civil asylums were converted into War Hospitals the medical superintendents received temporary commissions in the Royal Army Medical Corps, and many of the junior staff were often also commissioned in the army and retained. The male attendants were enlisted under a special arrangement, which gave them their chance of "doing their bit" in uniform. Perhaps one of the weakest links in the mental organization has been to find and retain sufficient skilled psychiatrists to staff the various War Mental Hospitals. This has been largely due to the fact that many medical officers who would have otherwise been available were called upon to undertake other medical duties, and the importance of a sufficiently large medical staff for such institutions is always underestimated even in civil asylums. It has happened, then, that medical men with insufficient or no experience have had tasks given them for which they were in no way fitted.

Let us trace the mental case from overseas to his final destination at home. We will suppose he is in the front

line, and in France or Belgium. The soldier himself may either report sick with evident mental symptoms, or with some complaint which leads his medical officer to suspect that mental disorder is existing. On the other hand, the onset of the mental illness may be reported to the medical officer by a N.C.O. who has seen or heard of peculiar and antisocial behaviour. In either instance the man is examined, and if presumed to be a mental case is admitted forthwith temporarily to the Field Ambulance, and at the earliest opportunity transferred quickly to a Casualty Clearing Station or direct to a Base Mental Hospital where mental specialists are in charge. It has been a strict regulation that some notes relevant to the patient's mental state should be made by every medical officer in charge of any station through which the case may happen to pass. At the Base, special Mental Divisions are set apart from other wards in General Hospitals under the ægis of a medical officer with special psychiatric experience. These Mental Divisions were located at Boulogne, Le Tréport, Rouen, and Havre, and by permission of the War Office I had the privilege of visiting and inspecting them and discussing the various mental problems of importance for the better co-ordination of the work with the officers in charge. The period of stay of the mental patients at the Base depended on the factors of physical condition, whether the number was sufficient for a convoy to be transferred home, and the availability of oversea transport accommodation. Some patients were perhaps at times not found psychotic, and were therefore not marked "Destination 'D' Block, Netley," but dealt with differently. Accordingly, convoys were irregularly sent to Netley as necessity arose, arriving by those hospital ships which had special accommodation for mental cases. The port of disembarkation for cases from the Western Front was always Southampton, but some convoys were sent via Dover. From Southampton the larger convoys were sent to Netley by ambulance train, whereas smaller batches were transferred from the docks by ambulance cars. A somewhat similar procedure was carried out in the other theatres of war, but the long distance and shortage of shipping transport made it necessary to retain the cases at their Bases a good deal longer, and larger numbers were therefore trans-

ferred at a time. Those cases which were of a more temporary nature, and which came from such distant districts as India, were often quite recovered on reaching England. In those Eastern localities the heat and other climatic conditions were trying, so that the voyage home and the change to a more temperate atmosphere had great beneficial effects.

At " D " Block, Netley, on admission the men at once had the luxury of a hot bath and clean clothing, a procedure in most cases very highly necessary. Those cases who were sufficiently well donned the blue hospital suits, while others for physical or mental reasons were put to bed under observation. Their old regimental clothing was returned to the quartermaster's stores after disinfection, and a new outfit drawn ready for them on evacuation. All personal valuables were checked, collected together into individual parcels, and placed in a safe for security till the end of their stay.

Shortly after a convoy arrived all the medical documents which accompanied them were noted and handed over to the medical officers for their use. Each patient was then examined after a précis had been made of the former notes from abroad. As it was needful so often to examine large numbers rapidly, the examination was always made on a more or less stereotyped plan. The previous history and family history were first noted, a rapid survey of his army career given, a few details as to the present illness from the patient's own point of view written up, and, lastly, a brief examination of the mentality made, adding any marked abnormal neurological signs or bodily lesions. One copy of this Case Sheet was forwarded on with the patient and his other documents and another retained for needful reference. If any case was regarded as never having been really psychotic, but suitable for a neurological department, it was promptly transferred elsewhere for treatment. Like politicians, doctors differ, and many cases sent under my care were diagnosed finally as psychoneurotic and disposed of accordingly.

Since " D " Block was purely a Clearing Hospital, and only had 124 beds available, it became incumbent on the officer in charge to evacuate as soon as a sufficient number were prepared for transference. The instructions were to be always ready night and day to receive cases from overseas,

and often the warning of fresh arrivals was very short. Transference took place to one or other of the War Mental Hospitals according usually to what accommodation they respectively offered. The men were then freshly clothed, and, attended by so many R.A.M.C. orderlies, were conducted to an ambulance train, which by arrangement came to the hospital station for this purpose. The party then travelled in comfort, and had thereby not only the surveillance of attendants but was supervised when necessary by the train medical officer.

The average stay at " D " Block was only five or six days, but the amount of work involved in this rapid clearing work, if efficiently carried out, may be gauged by a glimpse at the large chart, where can be seen the numbers that went through the above routine each month and year. How efficiently the work was carried out is testified to by the continued smooth running that went on uninterruptedly without any untoward happening, from the beginning of the war.

Of the 124 beds, 3 were for officers, and since this accommodation was so limited, their rapid evacuation was all the more necessary. The numbers of officers, though, were not large (see next chapter). If markedly psychotic, they were transferred to a special hospital set apart for this purpose near Richmond, Surrey; the milder states and those only showing psychoneurotic symptoms were sent to Lord Knutsford's Hospital, Kensington, London. The Maudsley Hospital in London also received those who had pure neurological disturbances. The same regulation applied to officers as to men as regards certification, in that they remained for twelve or nine months at the military hospital before being sent to institutional care under certificate, if such became necessary. From an intimate knowledge of the organization for the welfare of the Service mental patients I can testify to the fact that, when the initial difficulties were overcome, the system worked very smoothly, and the men could not justly complain of the treatment meted out to them.

In a circular on arrangements for the care of sailors and soldiers disabled by mental disorder the Local Government Board stated that, after consultation with the Ministry of Pensions, the Board of Control had issued instructions for the

special classification and treatment of cases of this kind. Where a soldier or sailor was discharged directly to an asylum, he would from the date of his admission be classed as a "private patient," and the cost of his maintenance would be paid by the Ministry of Pensions. It would be the duty of the medical superintendent to take up at once the question of the man's eligibility to be classed as a "Service patient," and, if so classed, he would receive certain further privileges. Service patients were to include all cases in which the malady was attributable to (that is, caused or aggravated by) war service. It would also include non-pensionable cases—that is, those in which the malady was not attributable to military or naval service, subject to the limitations (*a*) that the arrangement should not extend beyond the period of the war and twelve months afterwards; and (*b*) that it should not be applied to men who before enlistment had been treated in asylums. Where the union or parish to which a soldier or sailor belonged could not be ascertained, or where a man discharged to the care of his friends became worse and required asylum treatment, or where a man discharged on grounds other than those of mental disorder subsequently became insane, a summary reception order would have to be obtained for the man's admission into an asylum. In such cases it would be for the superintendent to take immediate action to secure the patient's classification, if eligible, as a Service patient. The proposal that Service patients should wear a semi-military uniform was abandoned, but suitable private clothing different from that of pauper patients would be provided, and a distinctive badge was to be worn on the jacket. Section 55 of the Lunacy Act, 1890, with regard to the sending of patients "on trial," would apply to these cases, but the period of trial should not exceed one month; during absence on trial a maintenance grant would be made to the patient or to his friends. Service patients were to be on the legal footing of private patients, and visiting committees were to have the power to discharge them. A Service patient whose discharge had been insisted upon by friends against the advice of the medical superintendent could not on readmission be again classified as a "Service patient" without reference to the Minister of Pensions. Since the main object of the scheme has been to

secure the happiness and contentment of the patient, and to consult the convenience of his friends, facilities were given for the transfer of patients to the neighbourhood of their families or friends.

It was not very long before the question of pensions for those who had been discharged the Service for mental disability became a problem which the authorities concerned had to face. For the purpose of discussing this a conference at the Ministry of Pensions was convened, at which I was requested to attend and give my views. At this meeting a special sub-committee was nominated to draw up some principles which might be placed before Pension Boards as a guide. The following scheme was drawn up and approved:

FORMULA TO ASSIST IN DECIDING THE ELIGIBILITY FOR PENSION OF A MAN WHO HAS BEEN DISCHARGED FROM EITHER OF THE SERVICES ON ACCOUNT OF INSANITY OR WHO HAS BECOME INSANE SUBSEQUENT TO DISCHARGE.

RULE I.—A man discharged on the grounds of certifiable insanity should be regarded as pensionable unless definite evidence is forthcoming that he was the subject of insanity (which includes idiocy and advanced imbecility) at the time of enlistment, or unless he is excluded by any of the conditions contained in the " Directions " attached hereto.

RULE II.—A man discharged on the grounds of certifiable insanity should, *prima facie*, be regarded as pensionable, although prior to enlistment he may have had one attack of certified insanity. When, however, a man has had more than one attack of certified insanity prior to enlistment, there must (to render him pensionable) be evidence that his present attack of insanity had been caused or aggravated by war service.

RULE III.—For the purpose of Article 9 of the Royal Warrant a man should not be regarded as pensionable if, during the period which has elapsed since he was discharged, he has been able to follow an ordinary civilian life, and no connection can reasonably be traced between the attack of insanity and the man's previous naval or military service.

DIRECTIONS FOR APPLYING THE FOREGOING FORMULA.

A differential diagnosis between the various forms of mental disorder, officially recognized for statistical purposes, is by no means an easy matter even in the hands of experts, and, in deciding whether a man's insanity has been caused or aggravated by service, such a diagnosis, except in the cases mentioned below, need not concern those responsible for the decision.

1. "*Congenital Mental Deficiency*" appearing on a medical report is an insufficient term to enable the case to be adequately considered, as it may include feeble-minded of high grade. High-grade feeble-mindedness (*i.e.*, feeble-mindedness of only moderate degree), though recognized medically as a predisposing cause of insanity, should be ignored in assessing a case for pension purposes.

2. *Insanity associated with Epilepsy.*—Epilepsy prior to enlistment should not disentitle a man to pension on the ground that the epilepsy has occasioned an attack of insanity which has occurred after enlistment

3. In cases of *Insanity associated with Syphilis*, including general paralysis of the insane, non-pensionability should be confined to those men who had shown definite evidence of cerebral disease before enlistment.

4. *Insanity associated with Alcoholism.*—(*a*) The following factors should not be regarded as unfavourable to a man's claim for a pension: Alcoholism following great mental or physical exhaustion, head injury, concussion, sunstroke, debilitating illness or fever, the result of war service.

(*b*) The following factors should be taken as unfavourable to a man's claim for a pension: Definite evidence that prior to enlistment he had had an attack of delirium tremens or been otherwise mentally affected as the result of alcoholic excess, or that he had been drinking heavily for a considerable period prior to enlistment or during his service.

From the outbreak of war to November 30, 1918, the number of cases of insanity officially pensioned for this disability is stated to be 4,801.

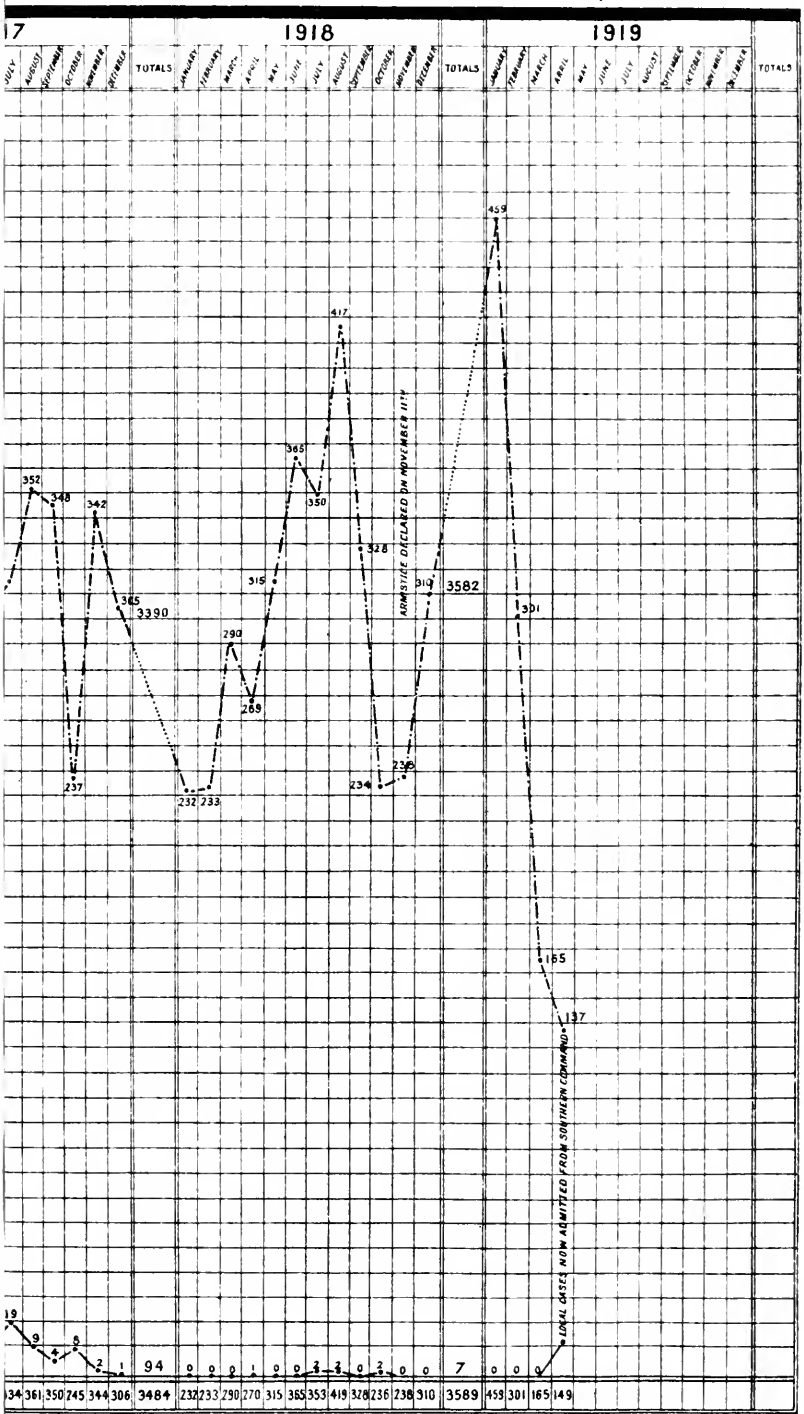
CHAPTER V

STATISTICAL FACTS AND FIGURES

SINCE every mental case occurring in the various Expeditionary Forces passed through the Clearing Hospital at "D" Block, Netley, I am in a position to give the exact number of cases that were so admitted from the commencement of the war. The details will be seen on the chart opposite. It will be seen that from August, 1914, to May 1, 1919, the oversea mental cases amounted to 12,320, of which 331 were officers and 11,989 N.C.O's. and men. It is very difficult to draw any deductions from the fluctuating monthly figures, though it is patent that a gradual increase took place during the summer months, when the main theatre of war was so much more active. Large contingents of cases from the East, however, might at any time arrive and unexpectedly swell the monthly number. The sudden drop to 137 admissions only in April, 1917, was due to the start of the submarine menace, and therefore a temporary cessation of the use of transports. In August, 1918, the number of admissions rose nearly to the maximum number since the beginning of the war, and it was at that period that the fighting on the Western Front was specially severe. Since the declaration of the armistice in November, 1918, the admission rate greatly increased, and in January, 1919, the largest monthly total had to be recorded —viz., 459. This came about mainly because large convoys which had been retained some time at the Ea tern bases were quickly returned home. After that date there has been a rapid decline. Elsewhere I comment on the fact, which is surprising to some, that so much mental disorder continued to develop after all hostilities ceased.

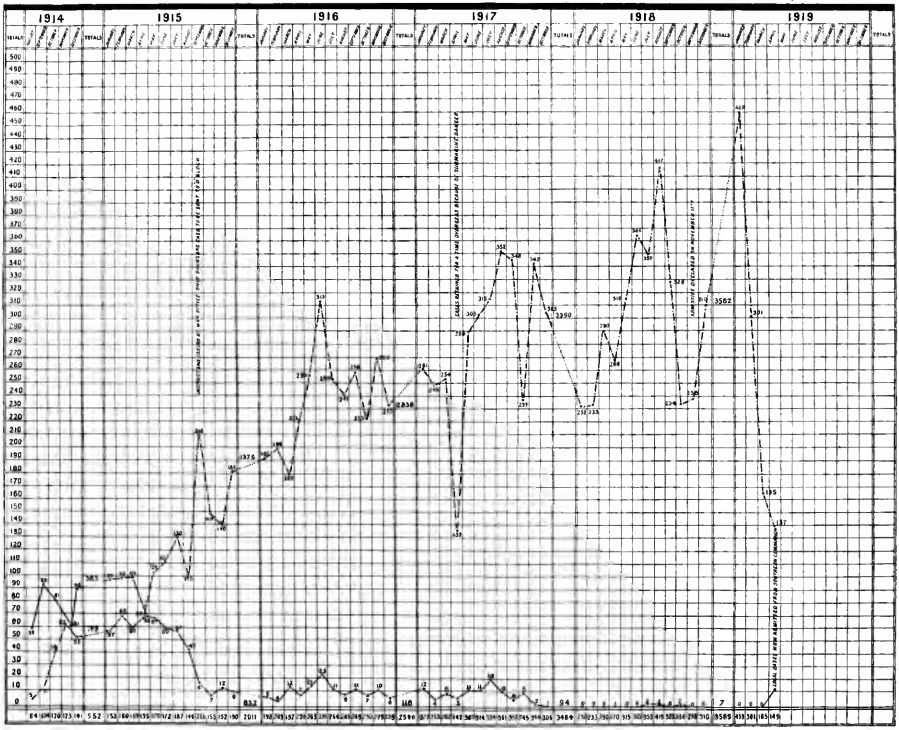
Of 3,000 consecutive cases that were admitted during the year 1917, I have followed up their careers nearly twelve months later by visiting the various War Mental Hospitals

Showing admissions to "D" Block, Royal Victoria Hospital Netley For Mental Disease during the European War.



CHART

Showing admissions to D Block Royal Victoria Hospital Netley For Mental Disease during the European War.



to which they had been transferred, and have made statistical notes thereon. From my results I can therefore give some interesting facts and figures which should prove useful in the future study of war psychiatry. The following tables mainly speak for themselves, though, where needed, some explanatory remarks are added:

TABLE I.—SHOWING THE VARIOUS THEATRES OF WAR THE 3,000 MENTAL CASES WERE ADMITTED FROM.

France	2,407	Foreign invalids.. ..	106
Mesopotamia	168	German East Africa ..	15
Egypt	160	Italy	5
Salonika	136	British East Africa ..	3

TABLE II.—SHOWING THE CONDITION OF THE PATIENTS TWELVE MONTHS SUBSEQUENT TO ADMISSION TO NETLEY.

	No.	*Per Cent.*
Recovered	1,376	45·8
Improved	387	12·9
No change	1,168	38·9
Died	41	1·3
Committed suicide	3	—
Escaped	5	—
Untraced	20	0·6

It is to be noted that the recovery rate would doubtless have been materially higher if it had been possible to trace farther the 278 cases who were repatriated to our Dominions at a comparatively early date. This, unfortunately, for many reasons, was not feasible. We may reasonably conjecture that a fair proportion of these cases would have regained their mental health within the twelve months period. I must also draw the attention of the reader to the fact (see Classification Table) that 13 per cent. were more or less congenital mental defects who naturally showed no change, and were at once discharged from the Service. If these are eliminated, the percentage of recoveries is raised to 52·6 per cent.

In studying these figures it must also be borne in mind that many types of cases were sent to Netley who would not for a moment have been certified as insane and committed to an asylum in civil life. This would apply to the mental defects, all of whom had earned their living prior to enlistment, to

many of the cases of anxiety hysteria, psychopathic inferiority, amnesias and amnesic fugues, and those with organic brain disease. A little reflection, therefore, shows that it is increasingly difficult to make any comparison with mental disease in civilian life. Though I am in a position to give the ratio of the number of mental cases admitted to Netley to the *average* number of troops on active service during the year 1917, such a ratio would be quite valueless and misleading, since, because of wounds, death, illness, and other reasons, this population was a constantly changing one, and no exact figures are obtainable of the true number of men who visited abroad during that time. Any comparison, therefore, with mental disease occurring in civil life during the same period is out of the question, and especially so as separate statistics have not been made for the latter with regard to the special age period of eighteen to forty years, within which period only the soldier mainly falls.

TABLE III.—SHOWING THE FINAL DISPOSITION OF THE CASES.

	No.	*Per Cent.*
Discharged from the Service	1,818	60·6
Returned to duty	215	7·1
Sent to asylums*	617	20·5
Repatriated	278	9·2
Died	41	1·3
Escaped	5	—
Committed suicide	3	—
Still in hospital	23	0·7

TABLE IV.—GIVING OTHER DETAILS OF INTEREST.

	No.	*Per Cent.*
Under fire	2,289	76·3
Not under fire	711	23·7
Previous attacks	293 (?)	9·7
Insane heredity	539 (?)	18·0
Had recent shell shock	123	4·0
Alcoholic history	393	13·0
Attempted suicide	105	3·5

Against the figures relating to the factors of previous attacks and insane heredity a query mark has been placed, because authentic information on these points was not sufficiently forthcoming. These numbers are, therefore, only

* As special Service patients (see previous chapter).

approximate, and in both cases, but especially the latter, it is probable that the number is a good deal under-estimated. Nevertheless, it was thought worth while giving them at their superficial value. The same to some extent holds good for the alcoholic history in as far as it relates to the drinking habits in civil life. In the army the observation of comrades and N.C.O's. was keen and reports of any alcoholic excess were, I believe, always made in the notes accompanying the patient when it had taken place.

TABLE V.—SHOWING CLASSIFICATION OF CASES.

	No.	*Per Cent.*
Dementia præcox	598	20·0
Manic-depressive insanity:		
Depressive phase	250	8·3
Manic phase	180	6·0
Simple depressed states	194	6·4
Confusional states	401	13·3
Including acute confusion ..	116	3·8
Simple paranoid states	260	8·6
Acute hallucinatory paranoia ..	233	7·7
Pure paranoia	10	0·3
Mental deficiency	388	13·0
General paresis	142	4·7
Alcoholic psychoses	49	1·6
Anxiety hysteria	46	1·5
Epileptic psychoses	38	1·2
Psychopathic inferiority	40	1·3
Associated with acute infective disease	24	0·8
Traumatic confusion	22	0·7
Amnesia and amnesic fugues	22	0·7
With organic brain disease	22	0·7
Acute hallucinatory delirium ..	5	0·1
Unclassified	76	2·5

In forming my classificatory list of the mental diseases met with I have not followed any official nomenclature, because I considered such eminently unsatisfactory, and a psychiatrist must in his own work be able to reflect his own views as to the most scientific way of grouping these disorders. As our knowledge of psychological medicine progresses we are in a better position to diagnose a case, but are less able to tack on any definite label, and especially so according to some textbook type. We really learn nothing by only tacking a label on to a patient's disorder, though it seems that to many complete satisfaction accrues when this is done, and

no further stage seems to be needed. One should look at the patient from the essentially human standpoint, endeavour to ascertain how the individual's natural strivings are hampered, how he has maladjusted, and what forces are at work to prevent the normal functioning of the mentality. Head lately made some pertinent remarks* on this point. He refers to this lazy and unscientific craze for pinning names on to diseases, and adds scathing but true remarks on the List of Diseases issued for the use of the army. In the light of modern knowledge one must agree with his statement that "impulsive insanity" usually means that the trained attendant thinks he has to deal with a "nasty" patient, whilst "moral insanity" is a police-court diagnosis. One cannot voice loud enough or sufficiently often Head's appeal to us to "clarify our notions of disease, and bear in mind that a name is not a diagnosis. The era of penny-in-the-slot medicine is at an end."

I have partly, therefore, only stated the nature of the mental reaction as simple depressed state, confusional state, or paranoid state, where the abnormal condition did not conform to any special disease recognized in works on the subject. Such terms as "confusional insanity" and "delusional insanity" are so wide as to become valueless. The former has not only been used for the toxic-infective psychoses, but also in almost any condition where confusion was a prominent symptom. As may readily be anticipated from what I have said in a previous chapter concerning exhaustion as an ætiological factor in the psychoses, I do not include "exhaustion psychosis" in my list, though it was a frequent label used by medical officers overseas. The old-fashioned term "moral imbecility" is also looked upon with disfavour, and such cases have been included in my class of "psychopathic inferiority," which is wider and more scientific. When the clinical material is discussed later, these points will be dealt with in more detail.

It might be well here to quote some statistics for comparison showing the prevalent psychoses occurring in home troops during the same period. Major Eager, the officer in charge of

* Henry Head, "Disease and Diagnosis" (a paper read at the Royal Society of Medicine, Social Evening, March 12, 1919).

the mental wards of the Lord Derby War Hospital, published an analysis of 258 cases that came under his care, but since he has used for that purpose an official nomenclature, his results are valueless for purposes of comparison. D. K. Henderson has published an analysis of 202 cases,* and in his article he makes the following statement: "There did not seem to be any one special type of mental disturbance to which these cases were particularly prone, and here we had a heterogeneous group of individuals all exposed practically to the same situation, but each of whom tended to react to that situation according to his inherent or predisposed constitution. The cases were not clear-cut, but frequently showed a mixing of symptoms and formed a composite picture. Before going on to discuss the individual groups, it may be admitted quite frankly that in several of these cases the formal diagnosis is quite open to question, but, owing to the vast numbers of cases passing through one's hands, and owing to the short time the majority of them were under observation this could hardly have been otherwise. After all, the labelling is not the important thing; it is much more interesting and stimulating to look upon these cases as reactions to situations which could not be adequately met." Henderson here strikes the same note that I just drew attention to. His 202 cases were differentiated as follows:

Mental deficiency	61	Psychoneuroses	10
Dementia præcox	43	Paranoid states	8
Manic-depressive	24	Toxic-exhaustive insanity	3
General paralysis	19	Epilepsy with insanity	3
Alcoholic insanity	17	Organic brain disease	2
Traumatic insanity	12		

One must refrain from making any scientific deductions of any value when comparison is made between my findings and the above figures, since the latter are founded upon such a smaller experience. One cannot help, though, at once noting the comparative absence of confusional states (toxic-exhaustive), which seems, therefore, to point towards some ætiological factor connected with active service in their production. The same applies to the paranoid states, which undoubtedly

* D. K. Henderson, "An Analysis of 202 Cases of Mental Disorder occurring in Home Troops," *Journal of Mental Science*, April, 1918.

were so much more prevalent in the cases overseas. Mental deficiency shows a much higher percentage, and also general paralysis; while dementia præcox is at about the same ratio, and manic-depressive insanity is rather less. The alcoholic factor is much larger than in my series, but most probably this is accounted for by the fact that at home there was greater opportunity for obtaining drink. It is only to be greatly regretted that the work of psychiatric medical officers has been such as to preclude them from making a deeper study of cases under their care, and finding more leisure to give the medical world analytic contributions which would have so greatly augmented our meagre knowledge of the factors underlying mental disorders.

CHAPTER VI

THE CLINICAL MATERIAL—DEMENTIA PRÆCOX

Considering that this is by far the most prevalent psychosis found in civilian life and in the ranks of the army during peace-time, it is not surprising that I found my largest percentage of cases—*i.e.*, 20 per cent.—grouped under this heading. The number really is a good deal smaller than might have been anticipated, and on more careful and scientific investigation it would probably be found that many other cases which have been placed in the categories of manic-depressive insanity, mental deficiency, confusional and paranoid states, may really strictly have belonged to the præcox group. The academic distinctions differentiating these conditions, especially when anomalous types are met with, are difficult enough to unravel even by those who are most qualified to judge, so that, when cases are dealt with by much more inexperienced clinicians and in the circumstances of war pressure, one can well understand these finer points of diagnosis being misinterpreted.

Hotchkiss* at Dykebar found 14 per cent. in his admissions, but adds that this number is probably too low, as the diagnosis was not made until the patients had been there for some time, and a number recently admitted, who were classed provisionally under manic-depressive insanity, might eventually prove to be cases of dementia præcox. It is often impossible to be certain that this condition exists until prolonged observation has taken place, as so many of the other mental reactions of war are akin to it in their initial phases. One saw large numbers who showed marked apathy and a shutting-off of external interests as leading symptoms, that in the absence of other diagnostic factors time often alone could be the test,

* R. D. Hotchkiss, "An Analysis of Cases Admitted during the First Year to Dykebar War Hospital," *Journal of Mental Science*, April, 1917.

and especially was this so as the previous history of the patient, which is of such vast importance as an aid to diagnosis, was frequently not obtainable. I was constantly deceived in this way, and other psychiatrists have had similar experience.

I strongly suspect that many of those who were regarded simply as mentally defective would have been found to be really mild cases of dementia præcox had they been analyzed more deeply. Many modern observers have drawn attention to transient attacks of excitement or confusion in those who were feeble-minded, which may be mistaken for some superimposed psychosis; and, on the other hand, Kraepelin considers that certain types of imbecility may be looked upon as infantile forms of dementia præcox. Wasner* points out the many interesting and important correlations existing between these two conditions. It has been demonstrated that feeble-minded individuals often show at the age of puberty or later an exaggeration of the mental defect coincident with the development of symptoms of dementia præcox, and that such combinations occur too frequently to be looked on as simply an accidental association. Some imbeciles may thus show, according to Kraepelin, certain symptoms with which we are familiar in the terminal stages of dementia præcox, such as emotional dulness with a shy and distant manner, negativistic traits, constrained and freakish behaviour. Catatonic symptoms, too, are known to exist in other psychoses than dementia præcox, and all late progress in psychiatric knowledge tends perhaps to show the intimate relationship that exists between the biogenetic psychoses. Nevertheless we must continue to do our best to make some classificatory distinctions, and my results in this direction, though the product of much care, have been, I fully recognize, much handicapped by conditions imposed by war.

Unfortunately, our knowledge of dementia præcox precludes anyone from being in a position to deal adequately with its relationship to the conditions of active service. It is not within my province in these pages to discuss at any length the current ideas regarding its pathology. Many facts, of course, point to its constitutional origin. The influence of heredity

* Wasner, "Psychosen auf dem Boden der angeborenen geistigen Schwächezustände," *Zeitschrift für die gesamte Neurologie und Psychiatrie*

and its frequent appearance at the adolescent period, often with such slight precipitating cause, lends colour to the view that the sufferer has only sufficient mental potential to carry him thus far, and he is "stranded on the rocks of puberty."

Of late years, owing to the research work done by the psycho-analytic school, the importance of the psychogenic factor in dementia præcox has been brought so much into the foreground that modern psychiatrists are becoming more and more impressed and interested in the evidences of mental conflict which the patients demonstrate, and are relegating the more fruitless materialistic point of view to a very subsidiary position. Though it is, of course, possible that some faulty metabolism connected with internal secretions of the sexual organs does take place, there is no evidence that this is a primary cause. The disease is shown more and more conclusively on study to have a right to be included in the biogenetic psychoses, in that it results from a faulty adjustment to life's demands, the content of the psychosis representing conflicts and reactions to conflicts which through a constitutional defect the individual cannot adequately handle. It has become patent also that disharmonies in sexual adaptations constitute themselves an integral part of the disorder, so that its common incidence at a period when special demands are made in the sexual sphere can be well understood. Even before this stage is reached, as Hoch has shown, there may have been manifestations of what he terms the "shut-in personality," in that the young individual tends to withdraw his interest from the external world and gain his pleasures in the land of phantasy. The sufferer then loses touch with the world of reality, which must continually conflict with his childish desires, so that danger of the development of an introversion psychosis becomes imminent when particular adaptations have to be faced. Negation of reality is perhaps one of the most fundamental human trends, but in dementia præcox this is manifested in an extreme degree. All emotion is jealously guarded for its attachment to unconscious desires and to self, so that apathy becomes the leading symptom, while others are the result of psychological mechanisms which have distorted the unconscious material.

The leading arguments against this conception of the

ætiology of dementia præcox are that an actual deterioration takes place mentally, and that actual alterations of organic structure have been shown to exist. Against the first, one must state that the deterioration is often, if not usually, only a seeming one, and that its manifestations may suddenly disappear; and to the second argument, one can say that the relationship existing between organic changes found in some cases and the mental symptoms of the disease is quite problematical. On the other hand, the psychogenetic outlook does give one an insight into the disorder, and renders the psychopathologist able to see a meaning in the grotesque behaviour and delusions, and shows him how the process is constructive, in that the patient is building up a world of his own in which he feels he can live. Jung, in his well-known monograph, "The Psychology of Dementia Præcox," shows this admirably by his analysis of a case. The reactions characterizing this disorder are best described by Adolph Meyer when he says they show "the existence or development of fundamental discrepancies between thought and reaction, defects of interest and affectivity with oddities, dreamy, fantastic, or hysteroid or psychasthenoid reaction, with a feeling of being forced, of peculiar unnatural interference with thought, etc., frequently with paranoid, catatonic, or scattered tantrums or episodes."

In the cases met with on active service a war colouring is naturally given to the delusional content. That those predisposed to this disease should break down under the influence of the stress and strain of warfare is not surprising, though one can only deal in vague generalities of any relationship between the two as cause and effect is spoken of. It is stated by some observers that fatigue, and especially mental fatigue, plays a prominent part in aiding the onset of the psychosis, and that unnatural fatigability is marked in these cases. Attention has been drawn in this respect to precocious young who, through excessive zeal in intellectual pursuits, have developed the disease, though perhaps the amount of mental work seemed to play a lesser rôle than the method of its acquirement, so that those untrained to stand the strain have been most liable to break down. Others have observed that when an ill-directed ambition has stimulated children of poor mental stock from rural centres to take up intellectual

pursuits in the urban centres, dementia præcox is not an infrequent result. These, I believe, are only superficial hypotheses, and at the most can only constitute themselves as slight contributory factors. One can well understand that fatigue may act as lessening resistance, but this point has already been sufficiently dealt with in a former chapter. At any rate, the factor of fatigue is prevalent enough in warfare to allow us to presume that in some manner it tends to enhance the development of psychotic symptoms in those so predisposed.

Alcoholism in dementia præcox must always, I think, be looked upon, not ætiologically, but as a symptom, and some psychiatrists lean to the view that the so-called alcoholic psychoses really prove to be, on careful investigation, abnormal mental processes of a præcox type, but with alcoholic complications. Mental conflicts, of course, must arise greatly on active service, and the manifold and complex adaptations required of the soldier must strain to the breaking-point the præcox constitution. What possible place is there for a "shut-in" type of personality amid the ranks of soldiers in warfare? Is it, then, any wonder that in such circumstances this psychosis develops? In the following case we can see the predisposing soil upon which mild symptoms showed themselves some months after going overseas.

Case 1.—Private C. M., *æt.* 23 years, was admitted to "D" Block from France, where he had been depressed and seclusive with ideas of self-depreciation. Said he was a malingerer, a prisoner, and a waster. He was a draper's assistant, unmarried, an only child. Had never had any special illnesses, but was always delicate and nervous. No venereal or alcoholic history. Family history showed no untoward heredity. Did well at school. After finishing his work in civil life he seldom went out, but would always stay at home and help his mother. On Sundays he went to church and out for a walk, but only with his mother, whom he would rather be with than anyone else. He had few companions, and was very shy with girls. Was always self-conscious, sensitive, and blushed easily. He attributes his illness to keeping indoors too much and to not mixing with girls as other young men of his age do. States he got on fairly well in the army

until a few months ago, and he then kept to himself and stayed in his hut as much as possible. Went to France six months ago, but has not been under fire. Says he would not help the other men, as they laughed at him and called him a German and a spy. The French women thought he was a French Jew and a spy. He called himself a Jew in his paybook instead of Church of England for "swank," and he has had to suffer for it. States he has been very lazy and not kept his kit clean, some of which he occasionally "sneaked." Thinks he should have worked harder and had been "swinging the lead." Though he overheard people calling him a spy he seems in no way unhappy, but expresses the desire to see his mother and then serve the King better. He answers fairly readily, but he is simple and his reasoning powers are poor. Memory and orientation good. Sleep poor. Dreams a lot, but cannot recollect their content. Physical nutrition good. Reflexes normal. Pupils dilated. Has a tendency to flexibilitas cerea.

His delusions and slight irrationality improved somewhat in a few months, and he was discharged home.

As is usual at the onset of dementia præcox, persecutory ideas were mostly in evidence, though, as I have previously pointed out, these paranoid symptoms tended to enter into the syndrome of most of the psychotic disturbances. The war colouring to symptoms is largely illustrated by the patient's delusion that he is regarded as a spy, and hallucinatory voices commonly utter the same accusation. That paranoid symptoms should occur so much in dementia præcox seems easier to understand if we accept the psycho-analytic point of view, as demonstrated by Freud, who has shown that there is a close connection clinically between paranoia, dementia paranoides, and paraphrenia (dementia præcox), and that the psychological bases of these three conditions are likewise intimately related. Ernest Jones* deduces from Freud's studies that these disorders respectively represent an increasing mental regression towards more and more primitive stages of ontogenetic development, and that we have here a psychological explanation of the familiar clinical finding that the same case

* Ernest Jones, "Inter-Relations of Biogenetic Psychoses" (Papers on Psycho-Analysis, 1918).

which at its onset appeared to be one of simple paranoia may later pass through the stage of dementia paranoides and terminate in a frank dementia. This view becomes the more interesting in our study of war psychiatry, as more or less purely paranoid states have been found to be extremely common, and I can only wish that I had had the opportunity of making a closer study of the cases to see whether in them any psychological correlation to dementia præcox types could have been traced.

Similar symptoms are seen in the next case, which seems to have been precipitated to some extent by a reputed shell shock. This patient was also somewhat feeble-minded, and the relationship between this and dementia præcox has already been alluded to.

Case 2.—Private D. B., *æt.* 26 years, admitted from France, where it had been noted, "Said to have had a shell shock some months ago, and six weeks later a change was noticed in him. Became suspicious, and thought everyone was plotting to destroy him. Says morphia is put in his food. Weeps copiously at times, and says he is taken for a spy. People seemed to sneer and made insulting remarks about him. Everything seemed to have some hidden meaning. Childish and below the average in intelligence." He was a farm-labourer, and said he had always had good health previously. A sister was insane once. Enlisted fifteen months ago, but could not get on with the marching, as his feet were deformed. Went to France three months later, where he was under fire. Except for an attack of trench feet nine months ago, he kept well until this illness. He is delusional, dull, and stupid, generally mentally defective, and does not adequately realize his position. He restates all his paranoidal ideas, continues to have ideas of reference, and expresses the hope that he is not going to be killed. Notwithstanding his false ideas, he is not unhappy or apprehensive, but evinces apathy and a lack of interest in the external world. No untoward physical signs were presented. He remained much in the same condition, showed unmistakable evidence of dementia præcox, and was finally committed to a civil asylum.

Under the influence of active service conditions it was by no means uncommon to get abnormal mental reactions which

in no way suggested dementia præcox, but in time symptoms of that disease appeared while under observation. In the following case only *nervous symptoms following a high-explosive shock were found.*

Case 3.—Private J. H., æt. 21 years, was admitted from France with the history that he had wandered away from his unit, seemed dazed, and had pains in his head. Two days previously he had been knocked over by a shell and lost consciousness. He was nervous, shaky, and sleepless. He remained nearly three months in hospital in France before coming to England. On admission to " D " Block he was much improved. His anamnesis showed that " he had always been in good health before, was sociable, steady at work, and had shown no early psychopathic traits. His father had committed suicide through drink. He himself was moderate with alcohol, and denied any venereal disease. He enlisted early in the war, and went to France six months later. Soon after his advent in the front line he was buried in a trench, was unconscious for a day, and, having nervous symptoms, was sent home, where he was in hospital for about two months. He feels that he has never been quite right since that time, and has always been vaguely nervous, but nevertheless returned to France six months ago. He says he did his best, but his heart was never in his work, and it was hard for him to carry on. He was often sleepless, had headaches, and at the beginning of this illness he found he could not keep up with his battalion, wandered away in a dazed condition and was placed in hospital again. At the time of examination now he says he is sleeping much better, his head feels clearer, and he feels altogether improved. He is correctly orientated for time and place and there is not the slightest evidence of any delusions or hallucinations. He is a distinctly nervous type, talks in a low voice, and is suggestible. Physical conditions good." At the War Mental Hospital he was transferred to he developed a gradually increasing apathy, with dilapidation and scattering of thought and mild delusions, so that he was committed to a civil asylum some twelve months later.

From the above history it would be easy, though extremely rash and unscientific, to assume that the shocks from high explosives had an intimate elationship with the after-develop-

ment of a deteriorating psychosis. There was no evident præcox soil, and the fact of the parental heredity leads us nowhere. Conclusions could only rationally be drawn from a study of many similar cases, but it unfortunately seems to be the fact that war pressure has largely obviated such being undertaken. It is certainly true that dementia præcox has at times developed after some such traumatic event, but the relationship of cause and effect is more than doubtful. The patients themselves often speak of a shell shock, but without good confirmatory evidence their word must often be doubted. The converse has frequently been in evidence—*i.e.*, that certain nervous and mental symptoms following a shell shock have been mistaken for signs of dementia præcox. In my earlier experience in neurological wards I often made such errors until further observation proved the falsity of my conclusion. Stuporous states were especially thought by many to be catatonic, and though this was not true, in all probability the same psychological basis exists for the symptom of stupor in both, though only temporary in the shell shock case—viz., an extensive negation of reality.

One must therefore frankly confess that we are not in a position scientifically to ascribe any particular ætiological factor in war as productive of dementia præcox, and we can only fall back upon vague generalities and point to the special strain endured by an individual who constitutionally is not in a position to adapt himself adequately as regards his mentality. Mental conflicts, only too easily set up in the environment of active service, will materially aid, while fatigue, bodily illness, and trauma will all add their quota.

CHAPTER VI

PARANOID STATES

Ever since my first experience of psychiatric work among Expeditionary Force cases I have been struck by the great prevalence of a paranoid trend in the symptoms shown. It has seemed to permeate into the clinical picture of a very large percentage of cases, even where the outstanding features were widely different. It was seen much among the mental defectives and manic-depressive types, while in the dementia præcox cases it was, as usual, a prominent early symptom. This paranoid trend as well constituted a *more or less pure paranoid psychosis*, with and without hallucinations, not infrequently with certain shell shock reactions and confusional states, while alcohol patently aided the development of persecutory ideas in others. Only a vague feeling of suspicion may have been present, or an indefinite sense that everybody was against the patient, or it developed still further with the appearance of unsystematized and systematized delusions. Though "paranoia" is occasionally seen in war classificatory mental lists, as a rule any recognition of paranoid states is conspicuous by its absence. Those cases which I think scientifically should come under this heading are grouped instead under the old-fashioned, vague, yet comprehensive term of "delusional insanity," or where a definite affective element is present with the delusions, they are included in the manic-depressive group. Others, too, are loosely placed in the category of dementia præcox, while many alienists jump at once to the conclusion that the patient has been taking alcohol to excess. Even if the alcoholic factor does enter into the history, this by no means throws any real light on the basic diagnosis.

Considering the fact that so much difference of opinion exists as to the classificatory rights of paranoid states—though scientifically such a point is of secondary importance—and

that there is so much discussion as to their real meaning, psychological basis, and prognosis, it will be well to devote some space to their elucidation from the point of view of modern work. This becomes the more necessary as I find that 8·6 per cent. of my cases were simple paranoid states, 7·7 per cent. evinced an hallucinatory paranoia, but only 0·3 per cent. the classical pure paranoia.

At the outset let me state that I group under this heading of paranoid states those cases where the main symptom consisted of persecutory delusions, usually with ideas of reference, where the mind is to a great extent clear, and where there is an absence of any marked affect except as a natural result of the supposed persecution. Hallucinations in some were present and were a marked feature, while in others none were manifested. As I have already stated, persecutory ideas constantly entered into the clinical picture of the war psychical disorders, but I have only regarded them as the primary feature of the psychosis under the conditions mentioned above.

Paranoia until very recently has always been regarded as a purely intellectual psychosis, in which reason was preserved but warped, and no longer in harmony with reality, especially in certain directions. Of late years this has been noted to be a false conception, as modern psychology has shown how dependent reason is upon emotion, and the delusional formation has become recognized as only an end-product that had deeper sources. This has led to a more profound study of the personality of paranoiacs, with a resulting advance in our grasp of the subject. The French school, in its doctrine of degeneracy, has not furthered our insight into these cases to any useful degree. Magnan's division of paranoiacs into those belonging to degeneracy and those akin to what we are now in the habit of classifying as paranoid forms of dementia præcox may be useful nosologically, but is arbitrary, and leaves out of account many types that can hardly be so classified. It has already been mentioned that psycho-analytically Freud takes up the standpoint that the so-called true paranoia, paranoid dementia, and paraphrenia have a close connection, and are but different stages in the same disease process. It seems that the more we understand the psychological bases

of the biogenetic psychoses, the more we see that there can be no hard-and-fast lines drawn between them, and that they are curiously related one to the other. Nevertheless, it is necessary to draw certain classificatory distinctions. Later work has seriously called in question the gloomy outlook that paranoiac disorders have always had. Mild and periodic delusional formations ending in recovery, with or without insight, have been described by many observers (Gierlich, Friedmann). Such conditions are commonly placed in the manic-depressive group, but I think unscientifically so in a great many instances. There is no doubt but that cases occur which show more or less systematized delusions of persecution, jealousy, and reference, without any melancholic or maniacal disturbances, when there is no clouding of consciousness, and which recover after a short time with insight. Unfortunately, it seems that we possess no criteria by means of which we can identify such cases at the start, differentiate them from the genuine chronic form, and prognosticate a favourable result. Because such cases do not conform to his definite prognosis in paranoia, Kraepelin assigns these to the manic-depressives, and he tends to do the same if a previously diagnosed paranoid dementia proves curable. This well shows how we have been too much disposed to depend upon the prognosis implied in the diagnosis.

Dividing paranoid cases into endogenous and exogenous, though working on the right lines of pathogenesis, does not often carry us very far, since it is so frequently impossible to know the characteristic personal traits that would help us. Friedmann thinks that in the endogenous forms we can deduce the delusional formation directly from a fundamental anomaly of character and of the intellectual constitution of the patient, whereas, when paranoidal ideas are shown in the manic-depressive psychoses, the delusions would be formed without essential continuity with the kind of mind in the days of health. He goes on to state:* "If an otherwise healthy person, especially a female, begins to fret about a troublesome experience, and then develops systematized delusions which do not spread into other fields, while the

* M. Friedmann, "Contributions to the Study of Paranoia," *Journal of Nervous and Mental Disease*, Monograph Series, 1908.

patient remains clear and presents no hallucinations, we have the prospect that the whole disorder will disappear in the course of two and a half to three years, probably without insight. In contrast to paranoia quærulans, delusions of reference develop which also are limited and circumscribed, and which disappear with recovery. The picture seems a mild systematized paranoia, though the emotional content seems greater than in the genuine chronic form. In these endogenous cases we are not, of course, surprised at similar attacks recurring." He compares this clinical picture with the mild exogenous curable forms, which it is difficult, he thinks, not to place in the manic-depressive group. In respect of this he says: "The mood is one of depression, and shows none of the aggressive, irritative affect so characteristic of paranoia. Ideas of self-depreciation or self-reproach are usually quite wanting. Ideas of reference and vague persecution dominate the picture. Also there is no plausible cause for the delusions, which are founded upon a general trend of feeling instead of a logical idea. We cannot trace a continuity between the delusion and the thought of the personality in the normal period. There is the good recovery, the strong tendency to recurrence, and at times they are followed by a definite melancholic attack."

Though many of the factors noted do point to a manic-depressive psychosis, nevertheless the absence of a marked and continued affect, the absence of self-accusatory ideas and thought retardation, militates against such grouping. Later I shall briefly quote some cases illustrative of this which I include in my category of simple paranoid states, and which recovered in under twelve months.

Birnbaum* agrees with Kraepelin that certain paranoiacs plainly arise on a psychogenic basis, denies the universal importance of the make-up, and sees that this is undoubtedly a field in which the further progress in the study of the paranoia problem lies. He calls attention to such factors as enfeebling disease, stress, over-exertion, etc., as possibly contributing to or creating the disorder upon which paranoia develops. This is evidently a point which should be intimately

* Birnbaum, "The Problem of Paranoia," *Zeitschrift f. d. g. Neurologie und Psychiatrie*, vol. 29.

related to active service conditions, and it is to be greatly regretted that this has not been, as far as I know, studied to any appreciable extent in the late war. My findings, however, would lead one to suppose that there is some connection between the factors Birnbaum mentions and war paranoid psychoses.

Concerning hallucinations, they may enter into the paranoid picture or not, and it is a moot point whether one should group hallucinatory cases into a separate category or not. In my results I have only done so where the hallucinations, which were always auditory, dominated the picture. Such hallucinatory paranoid states are much akin to, if not identical with, cases of acute hallucinosis. Believing as I do that this latter disorder is not essentially alcoholic in origin, because no toxic signs are usually discoverable, very definite psychogenic factors can be traced both to its precipitating cause and its hallucinatory content, and *exactly the same psychotic syndrome may be seen without any alcoholic factor being present.* I have included all such cases in my group of hallucinatory paranoia; and in this I think I am scientifically correct, for there is ample evidence that their psychopathological basis is not widely different from other forms of paranoid states.

In the light of modern research we must thoroughly overhaul our old ideas with regard to the relationship of alcohol and mental disease. This is not the place to discuss the psychology of alcohol, but its use tends to remove inhibitions, aid mental regression, and destroy sublimation, so that when taken in excess there is the likelihood, especially in those so predisposed, for dormant impulses and desires to be aroused which are out of harmony with the personality. The result involves a mental conflict, the abnormal resolution of which shows itself in psychotic symptoms. The alcohol here is a contributory factor in the causation of the mental disorder, but it is by no means a necessary one. Often enough the worry of some conflict comes first, driving the sufferer to drink as a narcotic. Many of my cases thus originated after a home leave, when they sustained some psychic trauma in the form of marital unfaithfulness, etc. We find, too, usually gross sexual elements in the hallucinatory

accusations, thus tending to show the psychogenic factor. Willige* thinks that there is a special paranoic disposition in the cases of acute hallucinosis, and Hoch holds that this presumed alcoholic disorder is fundamentally different from delirium tremens or Korsakow's psychosis. On the other hand, Kraepelin and Bonhoeffer do not see any essential difference, and they believe that if atypical cases are observed in large numbers, many points in common will be seen. In fact, Bonhoeffer regards acute hallucinosis as a modified form of delirium tremens, though I find it impossible to see how he does so. Both these psychiatric authorities tend to view their material from a materialistic and symptom picture point of view, and seem out of sympathy with the more modern psychopathological trends. Bleuler has put forward the suggestion that acute hallucinosis may be really a disorder of a dementia præcox type, and many others see a close relationship between these conditions. Kirby† speaks strongly in favour of my view-point, and calls attention to the absence of toxic-organic symptoms, the preceding emotional factor which seems to act, together with the alcoholic spree, as the precipitating cause, the utilization of the disturbing cause in the content of the psychosis, which also includes with striking uniformity adult sexual situations. He sums this up when he says: "The alcoholic hallucinosis would from this view-point fall into the group of constitutional reaction types or psychogenic disorders rather than into the group of specific reactions to alcohol poisoning." Schneider,‡ in a valuable paper on this subject, brings convincing evidence forward that acute hallucinoses should not be classed among the alcoholic psychoses, and illustrates his opinion by quoting many cases. He, however, thinks that they are allied to manic-depressive insanity. I have already mentioned why I do not think this quite scientifically feasible. In his conclusion he says: "Alcohol as a causative factor in the production of insanity has been overrated, incidence being confused with cause. Alcoholic hallucinosis is a misleading term,

* Willige, "Acute Paranoic Disorders," *Arch. f. Psychiatrie*, vol. 54.

† George H. Kirby, "Alcoholic Hallucinosis, with Special Reference to Prognosis and Relation to Other Psychoses," *Psychiatric Bulletin*, July, 1916.

‡ Carl von Schneider, "Studies on Alcoholic Hallucinosis," *Psychiatric Bulletin*, January, 1916.

because definite precipitating factors other than alcohol are present and necessary in its production, and alcohol is not even a necessary factor." In all this I cordially agree. I have dwelt on this alcoholic theme here because I am convinced that it is more intimately connected with the psychopathology of paranoid states than any other mental disorders.

Let us now consider the pathology of paranoia and paranoid states. Their most marked feature—suspicion—seems to be an emotion that is inherent in mankind, and presumably is a relic of that constant watchfulness for danger of attack from animal foes which primeval man must have constantly shown for his safety and defence. In the competition of modern civilization suspicion seems to be no uncommon reaction, especially in times of stress, and here, too, it seems to be defensive and self-preservative in nature. In some individuals, to be suspicious is a characteristic that is easily brought into play, while in others such an emotion is quite foreign. Shand* has recently pointed out that, though suspicion is one of the most tenacious of human emotions, it has been strangely overlooked by psychologists, and no systematic observations have been made concerning its development. He thinks that, notwithstanding its uniqueness and biological value, it seems better not to adopt the hypothesis of its being a primary emotion—at least, as far as our present knowledge is concerned.

Until of late pathological theories of paranoid states have been very vague, and have mostly dealt with factors which are taken at their surface value. The essential has been considered to be the association of certain ideas with such strong feelings that they become fixed and dominating. These, influencing the whole trend of thought, exaggerate ordinary events, bring about ideas of reference, and generally cause delusional elaboration. Gierlich seems satisfied with his explanation that the origin of paranoid delusions is found in a mental condition disturbed by violent and protracted emotions of expectancy, anxiety, surprise, anger, envy, etc., in combination with a weakness of judgment towards these

* Ernest Shand, "Suspicion" (paper read before the British Psychological Society, 1918).

highly accentuated ideas. Normal apperceptive synthesis is inhibited by the strong feeling tone, so that complex conceptions arise with all the force of a suggestion, leading to delusional conclusions in the sense of the conception. How it is that ideas do get such an emotional over-valuation and retain it is not in any way explained. Friedmann and Bleuler have taken much broader views, which led in the right direction, but the first systematic attempt to work out the causal interpretation of these states was made by Freud in an analysis of chronic hallucinatory paranoia.

It is only comparatively lately that psychology has been thought of any use as an aid in solving the problems of the psychoses. Instead, then, of only dealing with what was patently superficial, observers began to look beneath the surface of the seemingly grotesque insane symptoms, and at once began to see therein a definite meaning. It has only been by such means that any advance has been made in our psychopathological conception of paranoiac states. It is not feasible or judicious here to bring forward a great deal of evidence in support of the work that has been on these lines. Those readers who are sufficiently interested in the question can refer to Freud's original contributions on the subject or find the necessary material in Payne's critical digest of psycho-analytic researches on these lines.* Freud has put forward the relation of a paranoiac patient to his persecutor as follows: "The person to whom the delusion ascribes so great power and influence, in whose hand all the threads of the conspiracy converge, is, if he is definitely named, the one who before the illness had a similarly great influence for the emotional life of the patient or an easily recognizable substitute for this person. The emotional significance is projected as external force, the emotional tone inverted into its opposite; the one now who, on account of his persecution, is hated and feared is one formerly loved and revered. The persecution elaborated by the delusion thus serves first of all to justify the emotional change in the patient." Freud showed also that in the development of the patient's psychosexuality there had been some early "fixation," and that the

* Charles R. Payne, "Some Freudian Contributions to the Paranoia Problem," *Psycho-Analytic Review*, vol. i., Nos. 1, 2, 3, 4; vol. ii., Nos. 1 and 2.

weak place in that development lay in homosexuality, so that the centre of the mental conflict in paranoiac states is the demand of the homosexual wish-phantasy. Such a wish is so abhorrent to man that he only exceptionally permits it to enter consciousness, but through repression and later projection the wish is externalized in the delusions of persecution, jealousy, and grandeur. The mechanisms by means of which this is brought about must be studied elsewhere. The paranoiac sufferer, by the aid of his delusions, builds up some sort of world that he feels he can live in. It seems to be Nature's attempt at healing the psychical disease process analogous to the organic compensatory activities that take place in pathological physical disease.

Freud's ideas have been amply confirmed by others, of whom Ferenczi* stands in the forefront. He not only substantiates the homosexual factor, but assumes that the paranoiac mechanism occupies a middle position between the contrasting mechanisms of the neurosis and dementia præcox. Certainly all deeper psychological studies of functional mental disorder tend to show an inter-relationship. Maeder confirms Freud's assumptions in cases of paranoid dementia which he has published, and he has shown that in this disorder undoubted homosexual tendencies were disclosed behind the delusional ideas of persecution. There is, therefore, good reason for believing that homosexuality does not play an accidental part in the production of paranoiac states, but is more or less essential in its pathogenesis.

We have now to consider how what has been said may have relation to the soldier on active service. Why should he be specially prone to develop a paranoid reaction? First I would say that the soldier's environment and experiences tend largely towards this. We must bear in mind that the mechanism of projection is ordinarily one of defence. That which is perceived as of extra-psychic origin represents ideas which are painful to the conscious personality, and out of harmony with the ego-ideal. We never like to blame ourselves for anything, if possible. Self-reproach is too abhorrent to the conscious mind, and so the reproach is

* See S. Ferenczi, "Contributions to Psycho-Analysis," Richard Badger, Boston (translated by Ernest Jones).

projected. This is a common enough form of reaction in everyday life. Even children, when they hurt themselves against some object, such as the edge of a chair, are apt at once to show resentment against it and say, " Naughty chair." This personification of that which is obstructive is a primitive type of reaction, and can be profusely illustrated by customs of savage life. It therefore is likely to be of biological significance, and serves for the defence of the individual. Defence reactions, one can understand, are needful enough in so many ways in active service.

The mental defect often has some substantial grounds for his persecutory ideas, and it can be easily understood that, when poor reasoning and judgment are possessed, he should misinterpret much and exaggerate minor hardships. Human nature is cruel enough in ordinary civil life, but in the field during war the finer feelings are more than blunted, so that the soldier who shows any evidence of being " soft " is bullied, made game of, and tends to lead an existence which brings about the natural conclusion that everybody is against him. The whole trend of iron discipline fosters in some the idea of persecution, which becomes exaggerated in a mind that is morbidly disposed and that has become individualistic. When duties are not performed satisfactorily, the " bad workman blames his tools "; the soldier may take up a similar attitude. Morbid introspection leads to the arousing of old self-reproaches, conscious and unconscious, the resulting conflict tending so often to end in the mechanism of projection. Amid the horrors of war and the emotions that must often be aroused through personal worries and the thoughts of those who are near and dear, is it any wonder that certain ideas show an over-valuation ? At the same time it is not difficult to realize that at such times apperception is limited in its sphere of action through strong feeling, and this, added to the inevitable suggestibility of the soldier, marks out a splendid culture medium in which ideas of suspicion and persecution may flourish.

The necessary curtailment of free thought and action involved in army discipline naturally leads to much repression. There is so often little chance of an emotional vent being forthcoming which would relieve the pent-up tension, so that

disguised and distorted paths of outlet may take the place of ordinary free expression. With so many, when the path is blocked to a natural reaction of feeling, there is the danger of introversion being set up, and gratification in some way being gained by the satisfaction, if only in phantasy, of a discarded pleasure on a lower mental level. Not only in this way may the soldier in time of stress have his mentality regress to a latent homosexual trend, but the constant segregation among the male sex may also tend to the arousal of such desires, though in all probability it is but seldom that they reach consciousness because of the intense disharmony with the personality. It must also be borne in mind that heterosexual desire can find no outlet in most instances. The idea previously has been suggested that one of the unconscious incentives to enlistment was due to the buried wish for close male companionship, and there is reason for believing that many more of our actions are motivated from such a source than we should care to be aware of.

If we accept the hypothesis that the psychological basis of paranoiac states is of a homosexual nature, we can understand more fully why it is that the paranoid trend is so extremely common a reaction among the war psychoses. I am astonished that attention has not been drawn before, as far as I know, to the great prevalence of this trend. The majority of psychiatrists who have written on their observations have rightly insisted that there is no new form of mental disorder that is not met with in civil life, but they have not noted what seems to me such a marked feature.

I will now quote some cases to illustrate some of the points with which I have been dealing. The notes from abroad were often somewhat scanty and redundant, and here I only give what seems absolutely relevant. The following case is that of a young soldier with a neurotic temperament, who developed delusions of reference which might easily have passed on to a farther stage had he not been removed from his environment:

Case 4.—Private F. W., R.A.M.C., *æt.* 22 years, admitted to "D" Block, Netley, from France labelled "N. Y. D., mental."* His history stated that he said that he "felt

* N.Y.D. = Not Yet Diagnosed.

things were funny," and for some time he had been quiet and showed ideas of reference. He thought remarks in the daily papers were meant for him, and that all the conduct of his comrades had special reference to himself. Everything seemed contradictory to him, but he was able to give a clear account of his ideas. He arrived in England only ten days after his mental trouble was first detected.

On Examination.—In civil life he was a clerk; single. Ever since he can remember he was always self-conscious, shy, and bashful. It was always hard for him to get to know people. Never had any breakdown in civil life. His mother is very highly strung, and a maternal cousin had some nervous breakdown. No history of any alcoholic excess or venereal disease. He enlisted in October, 1915, and went to France in February, 1917, with a Field Ambulance. He never felt afraid under fire. He found the army life very hard; the routine worried him, and he found it difficult to make friends. Ever since joining up he has felt increasingly self-conscious; always he was being looked at, but never imagined he was talked about. He gives a good account of himself, and explains how he thought people were having a game with him. He can throw no light on his ideas of reference, but seems intuitively to connect them with his morbid self-consciousness. He now feels much better. The memory is good and he is fully orientated. He is steadily improving, and his ideas of reference are now disappearing. Physical health good. From the War Mental Hospital to which he was transferred he was soon discharged recovered.

Though to some extent it would not be hard to trace his false ideas to his sensitive temperament and the over-valuation of his ego, yet one must go farther to discover why these latter became so dynamic. Our study of the herd instinct tells us that the members of the herd must possess sensitiveness to the behaviour of their fellows, but this does not lead us far. The very shyness our patient complained of was unpleasant to him because he felt himself outside the herd. It is probable that his ideas of reference had their emotional birth in some old repressed self-reproaches which he projected, so that others in his environment seemed to take special notice of him. A general exaggeration of an ego-complex must,

too, have been present. Similar cases could be cited, but no good purpose would be served in so doing.

The next case illustrates the simple paranoid state that I found so prevalent among my war mental patients.

Case 5.—Private H. D., *æt.* 34 years, admitted from France labelled "N. Y. D., mental."

History.—"He has been under a system of persecution by the Brigade from the Brigadier downwards. His appearance is that of a man suffering from a grievance. He is off-hand and inclined to be superior. He has sought a commission, but from the Brigadier downwards they have tried to prove him insane, even organizing a stunt at Ypres to prove it."

On Examination.—A draper in civil life. Not married. States he has always been rather nervous, but never had to lay up for any nervous trouble. No alcoholic or venereal history, or psychopathic family history. He enlisted in March, 1916, and went to France eighteen months later, where he was under fire, but not unduly upset by it. States there has been trouble in his battalion caused by the officers and the Brigadier. The post of Aide-de-camp to the General was to be given to him, but they had an idea that his nerves were not strong enough. They put spies on him to see if his health would keep good. This worried him, and he began to have headaches. They tested him in many ways to see if his nerves were right, and always tried to "put the wind up him." He is somewhat exalted, and goes into minute details of how he was persecuted. He construed everything that was done in his battalion, even to their different movements, as done to persecute him. He answers readily, and his mind is quite clear. There are no manic signs, and his attention can be well held. His physical health is good, but he is inclined to be somewhat hypochondriacal. No abnormal neurological signs are found. He gradually recovered, and was discharged the Service.

Here there was no history of alcohol either in civil or army life, and no signs of any toxic disturbance could be detected. It seems in no way feasible to place such a case under the heading of a manic-depressive psychosis.

The next cases of hallucinatory paranoia shows the special psychogenic material having relation presumably to some old sexual conflict. Alcohol was here a contributory factor.

Case 6.—Private J. N., *æt.* 24 years. Admitted with the history that "he had wandered away in a depressed state, and said that five men were following him with sticks. He showed both homicidal and suicidal tendencies. People would always follow him about and say that he had connection with his wife when she was fourteen years old."

On Examination.—A butcher prior to enlistment, happily married, and had always had good health previously, though inclined to be nervous. No history of venereal disease, but had always been a heavy drinker, and had taken more than was good for him of late. He enlisted in August, 1914, but did not go overseas to Mesopotamia till May, 1917. Being under fire did not worry him in any way. In July, 1917, he was wounded in the foot and arm, and it was while in hospital then (six months ago) that his trouble started. He got depressed because everybody looked at him, and as he went about he heard them say, "That's him, that's him." Many people talked about him and accused him of having sexual intercourse with a girl of fourteen years of age. He still hears this going on, and is so worried about it that he would like to commit suicide and get out of it all. Says that he always used to be of a cheery disposition and liked company. He answers readily and rationally apart from his persecutory delusions, which have continued for six months. His memory is good, mind clear, and orientation normal. There is no insight shown. He eats and sleeps well, and has good physical health. Tongue clean, no tremors, pupils and reflexes normal. He quite recovered in a few months.

The constant recurring hallucinations with the alcoholic history would induce many psychiatrists to diagnose the case as one of alcoholic hallucinosis, but for reasons already given he should be included in the paranoid states.

The following case is similar, and, though alcoholic, it is patent that the real precipitating cause was the psychic trauma connected with his wife.

Case 7.—Private A. R., *æt.* 44 years, was admitted from France with the history that "He was found wandering by the Military Police. He had just returned from leave, and expressed delusions about his wife and sister. Said that he was followed about by five women. Later stated that, when

recently home, he found his wife had gone wrong and his sister was arrested while ' on the streets.' He heard his wife talking to him, and burst into tears. He feels that everything is against him; everyone talks about him, and makes insulting remarks and signs at him. States they despise him and will not associate with him. Hears his wife talking outside, and imagines she is with other men. She calls him filthy names and threatens to kill him. He wishes he were dead."

On Examination.—In civil life he worked in a cotton-mill; is married, with four children. Except for syphilis twenty years ago, he says he has always had good health. States that two sisters are " not quite right in their head." Served in the army before for eighteen years, but left with an indifferent character. Enlisted again in September, 1914, and went to France in August, 1915. Has often been crimed for drunkenness. Has been under fire, but not wounded at any time. Says he kept in good health till he was on leave last month. He then took a " drop " of drink, but was so worried, as he found his wife had been unfaithful. His delusions are now not so fixed, and the hallucinations are less, but he is still very worried over them, yet is not sure he would like to die. He thought he saw the " missus " last night, who was showing him the child who did not belong to him. He answers fairly readily and is well orientated. General physical state good, but the pupils are somewhat sluggish. No tremors, and the reflexes are normal. He soon afterwards recovered, and was discharged the Service.

It would be well now to quote a case where *the syndrome is exactly similar, but where alcohol can be quite excluded.*

Case 8.—Lance-Corporal J. B., *æt.* 32 years, was admitted from overseas with the following history: " On admission to hospital he was restless and apprehensive, with delusions of persecution. Stated that all the draft were ' getting on to him ' and threatened him. Said that wires were attached to feathers in his bed, and there was an electric battery there also."

On Examination.—In civil life he was a bank porter, was unmarried, had always had good health prior to enlistment, and was not nervous in any way. A brother had died in an asylum. No history of any alcoholic excess in civil life or

while in the army. He enlisted in September, 1914, and got on well with his training. Went out to Gallipoli in July, 1915, and early sustained a slight bullet wound in his arm. In September, 1915, he was buried through a shell explosion, but this seemingly had no ill effects. Later he was transferred to Egypt, where he had a quiet time, and it was when he was returning from a five weeks' leave that his mental illness started. He had been home for his father's funeral, since his mother was an invalid, and there was no one else at home. On returning to Service he was very much worried over the death of his father and leaving his invalid mother at home alone, but otherwise felt well. When on the boat he began to notice that the other men annoyed him gratuitously and persecuted him in every way, so that " his nerves gave way." He had never had any similar experience before, and he not only denies drinking himself, but there is no history of this from others. His comrades talked about him and called him filthy names, put electric apparatus into his bed, and put gas in the room, which made his lips swell. This depressed him a good deal, and he became sleepless, with pains in the head. On admission to " D " Block, the delusions and hallucinations were improving somewhat. He answered readily, showing no thought retardation, and memory and orientation were good. He had no insight whatever. His physical condition left nothing to be desired, and no tremors or any abnormal neurological signs could be detected. He recovered, and was discharged the Service just ten months later.

In the next case the homosexual element is patent, and there is no doubt but that his paranoid symptoms had direct relationship with desires of this nature, but which conflicted with his personality, so that they were projected into accusing voices from without. No alcohol could be traced in this instance either.

Case 9.—Sergeant G. R., *æt.* 51 years, was admitted to " D " Block from France with the history that he had lately " become very restless, agitated, and showed numerous ideas of persecution. He reproached himself greatly because he had learnt French from a boy, and he complained of people following him about and accusing him of all sorts of immoral

acts. This has worried him greatly and rendered him sleepless and depressed."

On Examination.—He has been an old solider who served his time and went on the Reserve. In civil life he had been a stockbroker's messenger, and had always had fair health. No trace of any bad alcoholic habits or venereal disease. No psychopathic illness in family as far as is known. He was called up in September, 1914, and went to France in July, 1915. After being under fire in the front line he was sent down to the Base permanently on account of his age. He says he kept in fair health until this illness arose. States that three months ago he took a fancy to a boy who used to visit him and teach him some French. He soon got the idea in his head that people might think he had immoral relations, but he vehemently and spontaneously denies that he ever thought of such a thing. Later he found that all the men were watching him and talking about him, and then began to accuse him of all sorts of bestial homosexual acts. There were constant hallucinations calling him names, "F—— pig," and saying "No bon." He suffered pains in his head and became sleepless, and the continual persecution depressed him. He answers quite readily and gives a good account of himself. There is no inhibition of thought, and his memory and orientation are quite good. Being an old soldier, he is also worried that his pension may be taken away, as everyone thinks him so immoral and bad. His physical nutrition is poor, but there are no abnormal neurological signs. He continued in much the same condition, had no insight, and was transferred to a civil asylum at the end of twelve months.

No good purpose would be served by quoting more cases, though I could freely illustrate how paranoid symptoms coloured and complicated so many various psychopathic conditions. The few that I have given are enough to illustrate the points I have endeavoured to insist on—viz., the psychogenic factors in the causation of paranoiac states; that alcohol is not a necessary factor in the hallucinatory forms, and, when existing, does so only in a contributory way, no toxic signs being found; that so-called alcoholic hallucinosis requires recasting in the light of modern knowledge; and that a very large number of paranoid states cannot scientifically be placed in the manic-depressive group.

CHAPTER VIII

CONFUSIONAL STATES

THESE states were fairly common—viz., 13·3 per cent.—and it is because of this fact, presumably, that it has been superficially supposed that some exhaustive factor must be the causative agent. The clinical pictures varied from slight obfuscation to stuporous states (9·5 per cent.), besides the acute confusions (3·8 per cent.) which more or less conformed to the textbook type of amentia. It is probable that the pathological basis of these cases varied a good deal, and one would hesitate much before attempting to classify them. Hotchkiss* gives 134 cases, or 16 per cent., of confusional insanity among his 831 admissions. Of these, he states that 27 were of the acute type, and often accompanied by considerable excitement. Eager† states his percentage of confusional cases as 10·8. Such variations are, of course, inevitable when different psychiatrists compile statistics. Unfortunately, the opportunity I had of studying my cases to any useful extent was so meagre that I must necessarily largely fall back upon conjecture as to ætiological factors and pathology. I include in these states those who showed confusion as the main form of reaction, but who did not present any special syndrome symptomatic of any definite disease. It was, of course, often impossible to differentiate those who might be in the initial stage of dementia præcox, and only prolonged observation negatived such a diagnosis. Present with the confusion a certain amount of apathy and emotional deterioration was often in evidence, but I believe that the exclusion of interest in reality has been generally a very prevalent psychological phenomenon in the

* R. D. Hotchkiss, "An Analysis of Cases admitted during the First Year to Dykebar War Hospital," *Journal of Mental Science*, April, 1917.

† R. Eager, "A Record of Admissions to the Lord Derby War Hospital," *Journal of Mental Science*, July, 1918.

sphere of war. A certain number of cases were, as far as one could see, due to a toxic influence, having followed upon such conditions as malaria, dysentery, or heat-stroke, though the relation between cause and effect was by no means always certain. In others there had been a history of some slight physical or emotional trauma, but in which again the connection was often doubtful. Early and authenticated histories were to a large extent lacking, so that psychiatrists at home were handicapped at the start in arriving at definite pathological conclusions. The malarial poison was a common offender, and every convoy from the Eastern sphere of war contained some patients suffering from a mild confusion with which frequently a more or less severe amnesia was shown. Those who had an undoubted history of physical trauma are spoken of separately later, and that these were not larger in number (0·7 per cent.) was supposedly because such cases found their way usually into neurological wards. Confusional cases due to alcohol are included under the alcoholic heading. Those that came under my care were not large, but I must frankly admit that some of my simple confused states may have had this origin in predisposed individuals, though the fact had not been ascertained or noted by the medical officers overseas. There were many cases that toxic factors were probably accountable for, but what those toxins were was by no means often obvious. In the near future physiological and chemical research may throw further light on the subject.

It is generally taken for granted that exhaustion is the primary factor in the causation of these conditions without sufficient clinical evidence of this. In the history obtained both from the medical officers and from the patients themselves one constantly failed to trace this source of disturbance. Many confusions are undoubtedly psychological in origin, such as those we see so commonly associated with mental deficiency. Maladaptable mentalities, when called upon more or less suddenly to face difficult and new situations, will naturally react in a confusional way from conflict of impulse. At times what is taken for confusion is really a dream state resulting from an inherent desire to negate reality.

War literature, up to the present, throws little if any light on this subject. The French school, who have contributed

most, either speak vaguely of physical or emotional shock, or state that alcohol has been the great offender. Mallet* devotes an article to confusional states, but his findings do not lead us far. Charon† regards psychopathic confusion as the most prevalent psychic malady among the French soldiers, but finds no difficulty in tracing its main cause in alcohol. In his clinical considerations he says: " Si le traumatisme et le surmenage de guerre sont indéniables commes causes efficientes de psychopathie dans un certain nombre des cas, il ne sont en verité le plus souvent qu'une cause occasionelle de 2e ou 3e ordre. Mais ce qui ressort dans toute sa gravité et toute sa laideur c'est la tare honteuse de 'alcoolisme, qu'on trouve comme cause efficiente indiscutable dans plus de 32 per cent. des cas. L'alcoolisme aigu étant bien la cause la plus fréquente et la plus immédiate de la confusion mentale, il ne faut point s'étonner de la prédominance énorme de toutes les variétés confusionelles dans les manifestations psychopathiques presentées par nos malades." This view is strongly supported by Lepine,‡ who in highly trenchant terms declaims against the enormous havoc that alcohol has wrought in the ranks. He speaks so vividly of its ravages both in mind and body that one cannot help but suspect he overdraws the picture. It has already been stated definitely that in the British Army this factor of alcohol can be laid down as the prevalent cause of but few psychopathic conditions.

The rôle that emotion plays in the causation of confusional states is by no means easy to determine, but it is feasible to presume that where a toxic factor is not in evidence in the history, and where evidence of such is absent in the physical examination, the condition may be of a psychoneuropathic nature. Many of these states were superficially complicated by vague symptoms of depression and fleeting delusions, often of a paranoid type. We may, then, roughly divide confusional states into those due to toxic causes, such as malaria, dysentery, alcohol; those due to psychic causes; and those due to trauma, such as concussion. The acute

* Raymond Mallet, " Etats confusionelles et anxieux chez le combattant," *Annales Médico-Psychologiques*, January, 1917.

† René Charon, " Psychologie de guerre," *Progrès Médical*, June, 1915.

‡ Jean Lepine, " Troubles mentaux de la guerre," Paris, Masson, 1917.

confusion of the amentia type is probably a more or less transition form between those purely exogenous and those that are endogenous.

Mental confusion may be sufficiently severe as to show evidence of stupor. The face is expressionless, external stimuli may produce no reaction, or there may be only slight movement of a defensive kind. The patient seems for the time neither to see nor hear, no words are uttered, and food is only automatically swallowed. He seems temporarily to be entirely unconscious of his environment, and to have an inherent unconscious desire to shut off reality. Examination reveals no sign of any lesion of the nervous system, but the organic functioning seems to be working at a low level. The condition varies in severity and duration, and the normal state is usually gradually regained. The milder cases can be temporarily roused, and their attention gained momentarily. Some may utter a few words connected with war experience, demonstrating a dream-like state. Lepine regards these cases as an annihilation of consciousness tired of struggling, the man becoming inert and subconsciousness carrying on. Defence mechanisms are not usually seen, and the condition may pass on into ordinary sleep. It is a sort of defence of the organism, and might be regarded in a biological light. Hoche regards such states as representing one of the typical biological reactions of the organism, a reaction of escape from the environment, and says it is quite in harmony with this and with the growing conviction that the essential motive in the functional psychopathic states of shell shock is a desire to get out of the situation, that stupor seems to be relatively frequent in the war. The stuporous states described among the prison psychoses would largely have the same pathology.

Confusional states of a less severe type are more frequent, and are characterized by defective attention, poor comprehension, more or less complete disorientation in time and space, slow cerebration, general emotional dulness, and a general blunting of all psychic functioning. Slight hallucinatory and delusional phenomena may be present, but are usually fleeting. The memory is often markedly affected, and anterograde amnesia is common, with not infrequently some confabulation. Though amnesia is an element in all confusion,

it is certainly more marked in war cases, so that Lepine makes a special heading of "amnesic mental confusion." As a rule nothing specially is complained of except some headache, and usually no insight is found. The clouding of consciousness gradually betters, and the prognosis is highly favourable. Roussy and Lhermitte* speak of a special aprosexic form which was described by Chavigny, characterized by the loss of voluntary fixation of attention, the patient being bright and active, the reverse of the condition in true mental confusion. To these authors it appeared that the sensations were not transformed into perceptions, but remained isolated and apart from the personality.

It is difficult to be sure of the exact percentage of simple confusional states that occurred on active service, because medical officers abroad often differed much in their conception of them, the majority simply regarding them as "mental," whatever the supposed ætiology may have been, while others looked upon them from a wider standpoint, did not think it right to classify them with the insane, and sent them to neurological centres, where they often recovered without being transferred home. It is certain that many of them admitted to "D" Block were scientifically more allied in their nature to the psychoneuroses than to the psychoses. The following case of confusion with amnesia illustrates this point. No definite cause for his condition was reported, and his symptoms point mainly to a simple psychological basis.

Case 10.—Private P. H., *æt.* 20 years, was admitted from France labelled "Confusion," and with the history that he had been found wandering, but was found not to be responsible. He had been confused and had no recollection of anything since he had been in the trenches. He had shown some improvement.

On Examination.—In civil life he was a fish crier, was single, and had previously been physically and mentally well. While in the army he had done well, and only once had three days C.B. for not cleaning his buttons. He was a teetotaller, and denied the contraction of any venereal disease. He enlisted

* G. Roussy and J. Lhermitte, "The Psychoneuroses of War," *Military Medical Manuals*, 1918.

in August, 1914, and went to France in January, 1915, being wounded on the Somme in the left arm in July, 1916. Returned to France in June, 1917. He knows that during the following months he had hard fighting and was heavily bombarded. There is no recollection of a period from late in September, 1917, when he was in the trenches at Messines, till he found himself in a hospital at Rouen. " It is as though I had flown there." There is no history of any accident or trauma, physical or psychical. When he came to himself he felt faint and dizzy, but had no headache. He still complains of feeling a little dull, and occasionally feels as though he does not fully comprehend what is said to him. There is no history of any delusions or hallucinations or any fits. He is now fairly orientated for time and place about two months after being first admitted to hospital. He is of good intelligence, and his memory is good except for the confusional period. Says that his mother is absent-minded. His head now feels clear, and he answers promptly and rationally. There is no evidence of any gross disease, and no abnormal neurological signs are found. He soon completely recovered.

This type of case of a simple confusion with amnesia has been by no means uncommon, and many akin to this have doubtless never been sent to " D " Block. They undoubtedly illustrate a psychological defence mechanism by means of which they unconsciously shut off the horrors of reality, and in their dissociated state live temporarily in a world of their own. These conditions probably do not in any way essentially differ from the amnesias and amnesic fugues I shall briefly refer to in a later chapter. The mentally defective are particularly apt to show simple confusion from their inability to adapt themselves for long to the conditions of warfare. Such have been extremely frequent, without any discoverable cause more than the continued strain to which they are subjected.

The next case is a common type that presented no psychotic symptoms other than simple confusion. Alcohol and trauma can be excluded, and he soon recovered his normal state when placed in an environment of a simple nature.

Case 11.—Driver A. G., *æt.* 24 years, was admitted from France, where it had been noted that " he had become nervous

and sleepless, and complained of pains in the head. He seemed more or less dazed, and could hardly answer questions. He was markedly confused, dull, and apathetic. Did not know where he was, and had no idea of time. Could not carry out simple orders very well, and forgot what he was told to do."

On Examination.—He was not married, and in civil life had been a horse-driver earning seventeen shillings a week. States he was a bad scholar at school, was only in Standard III. when he left, *æt.* 13 years, and now cannot write or read well. Says he always had fair health previously, but was nervous and was easily frightened. No abnormal history in the family was discoverable. He is a teetotaller. Enlisted two and a half years ago, has been in France for twelve months, and avers that he got on all right training. He has been under fire, and supposedly due to this he became more nervous than ever, and lately suffered much with pains in his head. He is now dull, stupid, and confused. Quite disorientated in time and place, but no other psychotic symptoms found. Reaction time to questions prolonged, and all ideation is slow. Eats and sleeps well, and his physical condition is good.

In the large majority of cases the abnormal symptoms following a so-called shell shock are emotional in origin, and not due in any way to trauma. Temporary confusion, with or without mild delusions and hallucinations, has followed on this experience, though out of my 3,000 cases only 123 had had any recent and near exposure to concussion from high explosives. The following case illustrates this type, and shows, too, the complication of ideas of reference. With rest, treatment, and change of environment, the confusion soon cleared up.

Case 12.—Private W. J., *æt.* 24 years, was admitted from France labelled "Confusion," and where seventeen days previously he had been sent to hospital, where it was noted he was dull, slow at answering or not answering at all. He had been blown up by a shell a few days before. His attention was poor and he often did not appreciate what was said. No information could be got from him, and at first even his name could not be ascertained. He had no idea of time or place. Complained of pains in his head and back. He

gradually improved, felt rather depressed, and felt that everyone was against him and looking at him.

On Examination.—A cook in civil life. Married, with one child. Had always had good health, and no neuropathic or psychopathic traits could be traced in him or his family. No history of alcoholic excess or venereal disease. He enlisted in October, 1914, and went to France in March, 1916, where he had been much under fire but had never been wounded. He stated that he kept in good health until he was knocked over by a shell explosion some three weeks previously. He knows that for two days he was shaky, restless, sleepy, and had pains in his head, but after this he recollected nothing for about ten days. Realizes that then for a time he was muddled and could not properly appreciate his surroundings or what had happened, and knows that he felt unhappy and that something was wrong. He now feels quite well, his mind is quite clear, and he is fully orientated. He answers readily and rationally, and his memory is good except for the acute period of his illness. Nothing delusional now exists, and there are no untoward physical signs.

Many psychiatrists, especially the French, have drawn attention to the great prevalence of alcohol as a causative factor in confusional states. I have already stated that I cannot subscribe to this view, though this toxic cause has been, of course, at times operative. The following is an example in a soldier who drank freely at times:

Case 13.—Driver B. C., *æt.* 43, was admitted from France, where he had been charged with being absent without leave. He had been drinking to excess, and his Commanding Officer stated that his record on service was not by any means brilliant. He had been admitted to hospital because he was confused, had no memory of what had happened to him of late, and gave a very poor and rambling account of himself. He was then disorientated, dull, stupid, and apathetic. At times he was emotional and fatuous, and showed tremor of hands and tongue. His pupils were sluggish and his patellar reflexes elicited only with difficulty.

On Examination.—In civil life he worked in a brewery. Was married. Said he had always had good health previously, but suffered often from headache, and at these times was

inclined to lose himself. He had been a heavy drinker at times, but had never been locked up for it. No insane heredity traced in family. Had never had any venereal disease. He enlisted in April, 1917, and went to France in October, 1917, but had never been under fire. Says he went to hospital because he lost himself, and was away from his camp for two or three days. Knows he had been drinking and presumes that that might be the cause of his loss of memory. At present he is much improved, does not complain of his head, feels quite happy and contented, and is orientated in all respects. No delusions or hallucinations are present, and his memory is fair. He answers promptly, but is somewhat dull, and there probably has been a falling away in his general efficiency. He is fully conscious of his past confusion and wandering spell. Pupils sluggish, but knee-jerks present. He improved still more, and was soon discharged from the Service.

From the Eastern theatre of war dysentery and malaria were very productive of confusional states as sequelæ, and there seems no doubt that the toxins and exhaustion from these disorders were often offenders in this respect. The next case illustrates this.

Case 14.—Private H. G., *æt.* 46, was admitted from Salonika labelled "Confusional insanity," and with the following history: "He was admitted to hospital with acute dysentery, temperature being over 100° F., and with blood and mucus in his stools. He improved fairly, but six weeks later began to show mental symptoms. He got excited at times, lost all sense of time and place, and imagined he had been absent from the ward and back to his unit. He was generally dull in his mentation, and his habits began to be dirty. For a time little sense could be got from him, but he slowly improved and he was evacuated home. No delusions or hallucinations were manifested."

On Examination.—In civil life he was a carter, and married, with one child. Stated he had always previously had good health. He had been always moderate with alcohol, and no hereditary predisposition was found. He enlisted in August, 1914, and went to Salonika at the latter end of 1916. He had previously been in the army, and served in the South African War. At no time was he under fire during the present

war. He remained in good health until he had dysentery three months ago, and he realizes that he got mentally upset, though he has hardly any recollection of that period. Feels his memory is still poor, and he is now imperfectly orientated for time, and is quite shaky in regard to his recollection of recent events, but there is no tendency to confabulate. He has been a steady man all his life, and is undoubtedly gradually getting well again. Physically he was in fair condition. He fully recovered in a few months, and was discharged the Service.

Though a good many soldiers who developed mental symptoms in India, Palestine, Mesopotamia, and Egypt regarded their disorder as due to the effects of heat, or to definite attacks of heat-stroke or sunstroke, I was usually inclined to be sceptical concerning these factors, though there is no reason why these should not, at any rate, act in a contributory way. A few, however, who had been specially reported on by a Medical Board were definitely labelled "Disability due to heat-stroke." The following case was so marked:

Case 15.—Private S. J., *æt.* 27, admitted from Mesopotamia, where he had heat-stroke twice recently, and his history stated "he subsequently became talkative, very confused, with a poor memory." He rambled much and talked a lot about "honour and truth," and said he was going to stop the war. Frequently he got excited, shouted out, "You won't crucify me; I've been crucified once already." At times became violent and threatening. This acute stage soon passed away, and he became quiet, though remaining confused. He seldom spoke unless addressed, and in no way appreciated his position. His bodily state seemed in every way normal, and he had no pyrexia. His mind gradually cleared, and during the voyage home he quite recovered his normal mental state.

On Examination.—A poulterer by trade in civil life, where he said he had always enjoyed the best of health. No previous nervous or mental trouble could be traced, but his father was in an asylum. No history of any alcoholic excess. He enlisted in September, 1914, and went to France in November, 1914, where he was much under fire, but seemed not to have been unduly upset by it. In November, 1915, he went to Mesopo-

tamia, where he was wounded in the hand in April, 1916, and was once hit on the head by a spent bullet. He knows he had heat-stroke twice, and was partly unconscious each time. He can only recollect anything of his mental attack towards its latter part, when he knows he felt muddled and everything seemed unreal to him. At the present time he feels quite well, with the exception of slight headaches occasionally. He answers readily and sensibly, and is well orientated. Shows normal conduct, and presents no psychotic symptoms whatever. No abnormal neurological signs were discovered.

Cases of confusion due to *Trauma* were not many in my admissions (0·7 per cent.), and doubtless most of them were cared for in neurological hospitals. Though in the early part of the war nearly all the mental manifestations of so-called shell shock were placed at the door of *commotio cerebri* by British writers on the subject, because superficially this materialistic basis seemingly had close relationship with the symptoms, and lack of psychological knowledge blinded them to other more important factors, it soon became obvious that hidden emotional causes were much more in vogue. Some observers, such as Mariet and Pieron,* have stated that they have established a distinction between the effects of the concussion of a shell and those of emotional shock, but most authorities are agreed that the differentiation of the two is hard and often impossible to demonstrate. Ballet and De Fursac† lay great stress on the point that moral shock may produce an identical picture to an explosive one. In times of war, then, when usually no history from eye-witnesses is obtainable, it is a hard task for the clinician to be certain how much trauma may have been a causative agent. Lumbar puncture in some cases has revealed blood in the cerebro-spinal fluid, and in fatal cases minute hæmorrhages into the brain have been found post-mortem, so that the possibility of organic change must often be borne in mind when no visible signs of injury are outwardly apparent. Unfortunately, my limited opportunity of investigating my cases precludes my offering any new products of study. Realizing the inadequacy of trauma

* Mariet and Pieron, *Bulletin de l'Académie de Médecine*, June, 1915.

† Ballet and De Fursac, "Les psychoses commotionelles," *Paris Médical*, January, 1916.

alone in producing confusional states, I was careful to pay special attention to the previous history and signs before labelling the case "traumatic." Friedmann's syndrome of headache, pains, dizziness, and intolerance to alcohol was seen in some, as well as the confusion, which varied in degree, though was usually not great. Mental dulness of all grades, with lack of interest and power of attention, was common, while some irritability and depression were often present too. This irritability was very marked at times, leading almost to a change of character. This is seen in the following case:

CASE 16.—Private H. B., *æt.* 23 years, was admitted from France with the history that "his sergeant had found him with a rifle in his hand threatening to shoot a comrade. He was placed under arrest, but later sent to hospital. It was found that since a trauma to his head in 1915 he had on several occasions been strange and muddled. On these occasions he was often a source of danger to his comrades. He was irritable, resented being ordered to do anything, and threatened violence if anyone touched him. He was somewhat confused, unstable, emotional, irritable, and had pricking sensations in his head."

On Examination.—In civil life he had been an apprentice to the motor trade, had always enjoyed good health, and was always moderate with alcohol. No hereditary predisposition to psychopathic disease traced. He enlisted in September, 1914, went to France in January, 1915, where he saw a good deal of fighting. In July, 1915, he sustained an injury to his head which rendered him unconscious, and he did not clearly come to himself until some hours later, when he found himself in a hospital train. He was sent home, and was altogether in hospitals some nine months. He had pricking pains in his head and had to keep quiet. When he attempted to work his head would start throbbing immediately. Since, he has never felt the same, and he describes a distinct change in his personality from what it was in civil life. He returned to France in August, 1916, was given light work to do, and this second time did not go into the trenches. He was about four miles behind the line, and whenever bombed or shelled he used to shake very greatly. He admits having had an argument with a comrade, but denies threatening to shoot

him. He complains of headache, feels bad generally, and is especially dizzy. Is now approximately orientated for time and place, but does not correctly understand his position. His reflexes are very exaggerated.

The acute confusional states, of which there were 3·8 per cent., require no special discussion. They were mainly of the amentia type, which seems a transition condition between those that are purely exogenous in origin and those largely due to psychogenic factors. The differentiation from manic-depressive states and dementia præcox was often not easy and not settled until observation had been prolonged. There were varying degrees of clouding of consciousness, more or less incoherence with retention and attention disorders, complete disorientation, fleeting delusions and hallucinations with a war colouring to their content, and increased psychomotor activity. As is usual, the general health was poor, and tube-feeding was at times needed. The recoveries in the confusional states, including the acute forms, were high.

CHAPTER IX

MANIC-DEPRESSIVE INSANITY AND SIMPLE DEPRESSED STATES

It is not surprising that under the conditions of active service depressed states should be much in evidence, and more so than excited reactions, since all the circumstances of the soldier's life would naturally tend more in this direction. Among my 3,000 cases I found that the depressive phase of manic-depressive insanity manifested itself in 8·3 per cent., and simple depressed states amounted to 6·4 per cent., while the manic phase was seen in only 6 per cent. The percentage of the depressed cases conforms with the figures given by Hotchkiss,* but who found his manic types surprisingly small in number—viz., 3·2 per cent. Birnbaum† gives the percentages of manic-depressive insanity in the German Army at the commencement of the war, according to Bonhoeffer, 3 per cent.; Meyer, 4 per cent.; and Hahn, 2 per cent. Such figures probably increased largely in later years. Had I placed my paranoid cases under this heading, as so many psychiatrists have done, the manic-depressive group would have assumed vast proportions. A very large number of depressions were only secondary to paranoid ideas, and I have placed here only those cases in which a disturbance of the affect was the primary and essential manifestation. This point has already been dwelt on in my chapter on paranoid states. Whether or no involutional melancholia should be regarded as a separate disease entity from manic-depressive insanity does not concern us here, as the average age precluded any such diagnosis.

* R. D. Hotchkiss, "Renfrew District Asylum as a War Hospital for Mental Invalids, with an Analysis of Cases admitted during the First Year," *Journal of Mental Science*, April, 1917.

† Karl Birnbaum, "War Neuroses and Psychoses according to Observations made in the Present War up to March, 1915," *Zeitschrift für die gesamte Neurologie und Psychiatrie*, Referate und Ergebnisse, 1915.

There is abundant evidence in the histories of these affective psychoses to recognize their psychogenic origin. The experience of some personal worry was hardly ever conspicuous by its absence in the anamnesis. The wonder is that so comparatively few maladjusted themselves mentally, when we realize the mental conflicts so many must have had to face. Though crowd suggestion tends to banish personal feelings, the loss or diminution of the herd instinct must arise at times when the individual feelings come to the fore and introspection comes about with its morbid tendencies. Home worry was a prevalent factor in the engendering of a mental breakdown, even in those who had previously shown no psychopathic characteristics. The constant stern demands of duty, though hearts are sore and souls in pain, must produce mental conflicts difficult of rational adjustment. As the emotions so largely, in such an environment as the soldier's, must be repressed, is it any wonder that many develop morbid symptoms? Depressed anxiety and morbid apprehension are seen in the milder cases, and intense depression in the more severe. The feeling of diffuse anxiety and that some unknown harm is going to arise is so frequently met with that Lepine makes a definite class of these cases under the term "anxious insanity," which he thinks more fitly describes them than melancholia. He states that the soldier is seen to be more and more asocial and self-absorbed, and seems to distrust all his comrades. The disordered ideas are founded on fear, not of the enemy, but of derelictions of military discipline, of being in the wrong, going before a court-martial, and being shot. He waits for his punishment, and sees references to it everywhere. He knows he is going to be shot, but not why, and has to rationalize a crime of some sort. Hence self-accusations arise which may be the first outward sign of the trouble. It is quite true that this is by no means an uncommon picture, and Lepine is right in drawing attention to the prevalence of anxiety in the syndrome. This fact, though, only confirms my statement that this psychogenic factor is at the root of the psychosis, for some morbid anxiety is a product of mental conflict that arises from impulses contrary to the individual's ego-ideal, and thus answers the same purpose as natural fear in

that it protects the personality from desires of which it is afraid.

On this question the psycho-analytic authority, Ernest Jones,* says: "(1) As the condition frequently occurs when the bodily health is, so far as can be determined, otherwise perfect, there is no evidence in support of the views either that the nervous centres are in a state of primary over-excitability, or that abnormal irritative impulses are arising in any pathologically altered visceral organs. (2) Morbid anxiety and its physical accompaniments are essentially an exaggerated mechanism of a normal biological instinctive activity, the function of which is to protect the organism against pain (in the wide sense). (3) As the outburst of anxiety frequently takes place as a reaction to trivial occasions, which in the normal give rise to little or no anxiety, and also occurs quite spontaneously, independently of any ascertainable external cause, it follows that the external agents (including here, also, ideas of danger, etc.) cannot be regarded as the true cause of the anxiety, but at most as working factors." Jones later states that the unconscious desires of which the individual has conscious dread are sexual in nature. In the chapter on "The Psychology of the Soldier" I dwelt on this point as a factor not to be lost sight of when the habits and circumstances of civilian life were exchanged for the necessitous régime of a military career, and this holds good the more when in the active theatre of war. It is an interesting question as to whether many of the anxiety states are not due to ungratified desire, and also fear of this desire, should opportunities arise for gratification, but in circumstances perhaps contrary to the ego-ideal of the soldier who has left a wife at home.

The term "anxiety psychosis" is by no means new, as Wernicke years ago grouped certain disorders under this heading, but without agreement with most observers. Anxiety, though, may occur as a symptom in many psychoses, and probably has then the signification spoken of by Ernest Jones. Mention should be made here that a certain number of depressed states seemed, as far as one could tell, to have no

* Ernest Jones, "The Pathology of Morbid Anxiety" (Papers on Psycho-Analysis, 1918).

psychogenic origin, and had some seeming relationship to the effects of heat or malaria in those who had seen service in the East. Headache, too, was often a prominent symptom. Major Rawling* has drawn attention to some cases that might come into this category. He thought that, as the result of malaria or heat-stroke, a toxic condition might be set up which, acting on the choroid plexuses, led to an increase in the rate of secretion of the cerebro-spinal fluid. A possible resulting cerebral œdema gave rise to symptoms of headache, with irritability, despondency, and marked exaggeration of both superficial and deep reflexes. Epileptiform convulsions occurred as well. Though I have no special reason to think that many of my cases were due to any cerebral œdema, I must, in scientific fairness, not negate the possibility that some toxic cause may have been at work in some, and especially in those definitely following upon such illnesses brought on by trauma, malaria, or heat.

As in manic-depressive states generally, self-accusations and the symptoms of a morbid conscience were frequently in evidence, and not seldom could they be traced to auto-erotic associations, upon which it is presumed their pathology depends. With the time and opportunity at my disposal it was not possible to trace how much these affective psychoses had relation to the personal make-up, but sufficient evidence was often obtained to be sure of their endogenous formation. Those I have grouped under the manic-depressive heading showed distinct retardation of thought, which must be taken as an important symptom, while the simple depressed states did not evince this, and either no causative factor could be traced by physician or patient, or the condition answered to Hoch's description of "reactive depression," where a definite cause for worry originated depression and remained in the mind all the time with an exaggerated emotional value. Thus mistakes of omission or commission made in their duties, personal differences with comrades, or the performing of seemingly unsatisfactory work, all became a source of worry which, through morbid introspection in times of emotional stress, gave it an enhanced and fixed importance. This

* L. Bathe Rawling, "Cerebral Œdema," *British Medical Journal*, May 4, 1918.

over-valuation must arise from emotion which has been repressed in the past in connection with associated experiences. The short duration of some of these cases when placed in the right environment at an early stage has been marked. The following case of reactive depression quite recovered in a month from his first admission to hospital, even though his depression had led to an attempt at suicide.

CASE 17.—Sergeant J. R., *æt.* 40, was admitted from France with the history that a month previously he was admitted to hospital with a self-inflicted wound of his neck. It was reported that for a short time he had been somewhat depressed, and had kept a good deal to himself and had slept badly. On admission he was depressed and agitated, somewhat confused, and had no recollection of having injured himself. The wound was stitched up and dressed, and soon healed up without any trouble. In hospital he gradually slept better and became more cheerful.

On Examination.—In civil life he was a manager in a shop, and married, with two children. He had always had fair health, and had had no physical illness worthy of mention, but had always been nervous and liable to get depressed when things did not go well with him. Nevertheless, has never had any nervous breakdown. No neuropathic or psychopathic traits in his family history traced. Denies any venereal disease and alcoholic excess. He enlisted in June, 1917, and went to France the same month. At no time had he been under fire, and he had kept in good health until this illness. He states that a few weeks before the onset he had worrying news about his family from home, and he was unable to banish this thought from his mind, though he tried hard to do so. At the same time he had extra responsibility with his work, which he says made it harder for him, so that when alone he would brood on these things. Depression, insomnia, and headaches then quickly supervened, but he would not report sick and carried on all the time. Thoughts of ending his life did enter his head, but he denies that he seriously intended to injure himself. He has complete amnesia for the throat-cutting incident, and was surprised to find himself in hospital with bandages on. He now complains of nothing, seems quite well, and answers readily and rationally. A well-

marked scar is seen on his throat. His physical state was good, but his patellar reflexes were exaggerated and there was a tendency to tremor of his outstretched hands. After resting for a couple of months at a War Mental Hospital he was discharged to duty again.

Among my cases were 105 who had attempted suicide, and a fair majority of these were those who came under the heading of manic-depressive or simple depressed states. Three patients succeeded in their suicidal endeavour after having been transferred to a War Mental Hospital.

The *manic* cases amounted to only 6 per cent., and in no way differed from the type met with in civil life. Some were acute, others subacute and not a few were only hypomanic. The delusions naturally constantly showed a military colouring. Lepine draws attention to the fact that one sees more of the hypomanic types, as in the army they are taken in time. This author's fondness for the ætiological factor of alcohol leads him to state that the war manic is often an habitual drinker who is generally considered sober, but some day, following fatigue or some war incident, becomes maniacal. Having only seen my cases at home, I am not in a position to categorically deny such an observation, but from the histories obtained and my own anamneses I cannot confirm it, and strongly doubt that such was the case among the British soldiers.

CHAPTER X

MENTAL DEFICIENCY

PERHAPS the first thing that would have struck the average observer, had he seen a collection of mental cases from overseas, would have been, I think, the outward and visible signs of general mental deficiency as depicted upon the faces he saw before him. Though facial expression and features are but poor and superficial guides in this direction, in the main he would be right in his assumption that a very large proportion of the men had a subnormal mentality. It is true that the expression of those who are confused and apathetic tends to lend the countenance an expression and appearance which are deceptive. It is surprising how when the confusion disappears and more interest is taken in the environment, the previous impression of intellectual defect vanishes at the same time. As large a number as 13 per cent. of my 3,000 cases had to be placed under this heading, and I am not here including those defectives who had a definite superimposed psychosis as well. Hotchkiss at Dykebar War Hospital found in his 831 Expeditionary cases in 1916 that 18 per cent. were mentally deficient, but for practical purposes he divided them into two classes—the vicious or moral imbeciles, and the ordinary defectives. The former are mainly included in my category of psychopathic inferiors, which term I prefer to that of moral imbecile, and which Henry Head describes as "a police-court diagnosis." Major Eager at the Lord Derby War Hospital, in the analysis of 2,429 cases that passed through his hands, found 13·8 per cent. of mental defects. The figures, therefore, of others largely agree with my own. As far as I know, no Binet-Simon or similar mental tests were made in these cases, so that no definite statistics exist as to the degrees of defect that were present.

There is no doubt that the question of mental deficiency,

using the term in a wide and scientific sense, was one of the most important with which the recruiting authorities had to deal. It seems, though, in many instances that such authorities took no heed of this point, notwithstanding the obvious outward and visible signs of degenerative stigmata which should have led them to seek farther for corroborative evidence. I give below a table showing the number of mental defectives who served abroad for six months and under.

Out of 388 mental defectives, 184 served abroad for six months and under. Served abroad :

6 months only	22	3 weeks only	8
5 months only	17	2 weeks only	6
4 months only	22	1 week only	2
3 months only	46	6 days only	1
2 months only	32	3 days only	1
1 month only	26	1 day only	1*

Yet there are many factors connected with the enlistment of these defectives which at first may not be thought of. It is astonishing to note the length of service of some of these men, who arrive home with reports of their uselessness and their having been a danger to themselves and others. But on tracing their history, one finds that so many were never permitted to use a rifle, and for a long period of time had only been performing menial duties, and only perhaps broke down when the slightest responsibilities were given them. A large number of such men were incorporated in the Labour Battalions, where it was presumed that a mental defect was of small account. We see here the idea carried out that if a man can do any work in civil life, he can do it in the army and can do it overseas. Unfortunately, though, practice did not bear out any such theory, as any psychopathologist could have predicted. Poor-witted farm-labourers, who have lived in the most simple surroundings all their lives, could not adapt themselves for long in an army organization, and still less so when having to work under shell fire. With the games their comrades played upon them and the stern treatment meted out to them by their N.C.O's., is it any wonder that they developed some confusional symptoms, that they got persecutory ideas (which so often had a true basis), and showed

* Only enlisted ten days previously.

stuporous and other psychopathic states? Mental adaptability is something that one cannot weigh in a balance, measure in mathematical terms, or predict with certainty. How hard it is to prognosticate on such a question is shown by the surprising number of mental defects who *do* somehow or other adapt themselves normally for a surprisingly long time. One can, therefore, have some sympathy with the military authorities if they took up the attitude that they required the services of every available man, that no one could say with any exact certainty how long a certain type of mental defect might be useful, and that it was worth their while to risk recruiting such a man on the chance of his being able to serve his country for some fair period of time. The psychiatrist sees mostly one side of the picture, and it is possible that perhaps he takes a too academic point of view. Nevertheless, one would be fair in saying that recruiting authorities were far too careless generally in this and in their attitude towards the neuropsychic constitution of the men brought before them. One must bear in mind, too, that this had an important bearing on the swelling of the enormous pension list, which might have been to some extent obviated. In the American Army 21,000 men were rejected on account of nervous and mental disorders, of which number practically one-third were feeble-minded.* It will, indeed, be interesting to see what percentage of mental disabilities through active service the American Army will show in the face of the careful and scientific methods they pursued in order to eliminate the neuropathically and psychopathically unfit.

Yerkes† says: "It is commonly supposed that psychologists are eager to select and eliminate the feeble-minded from the Service, but those professional experts who are thoroughly conversant with the military situation and with the possibilities of their methods of examining are far more interested in properly classifying the mentally defective. The fact is that in military, as in industrial, organizations reasonably suitable places can be found for those of little intellectual capacity quite as readily as for those of great ability. In connection

* George A. Hastings, "Registration of the Feeble-minded," *Mental Hygiene*, October, 1918.

† Robert M. Yerkes, "Relation of Psychology to Military Activities," *Mental Hygiene*, July, 1917.

with the preliminary handling of recruits, it is the prospective function of the examining psychologist—first, to aid in the elimination of those who cannot safely render service worth their hire; second, to indicate various degrees and kinds of special ability, and to relate them to the tasks of army or navy, so that each individual shall be placed in a position of maximum usefulness; and, third, to detect those who by reason of mental instability or psychopathic condition demand the attention of the medical expert." This undoubtedly strikes the right note, and well shows the duty that devolves on the recruiting authorities, of which one member should be a mental expert.

Lieut.-Colonel Salmon,* of the U.S.A. Army, however, believes, in spite of arguments advanced to the contrary, that experience in the present war has proved that mental defectives should be debarred from military service, except when the last available man-power must be utilized. In such circumstances, they should be kept at work at the rear under the supervision of non-commissioned officers specially trained in their management. Goddard,† who is eminently qualified to speak on such a subject, has pointed out how the presence of the mental defective in military life is a real menace. He emphasizes the necessity of recognizing the mental status of all enlisted men, and fitting them to their jobs according to their individual degrees of intelligence. Every officer should understand that mental incompetency explains the action of the unsatisfactory recruit more often than any other cause. Schaffer has pointed out that the feeble-minded in the German Army are the objects of mistreatment at the hands of other soldiers; they are repeatedly in conflict with discipline and military laws; they are notoriously intolerant of alcohol, and when under its influence frequently commit military crimes; they are emotionally unstable and irritable, and especially characterized by unreasonable outbreaks of temper and assaults upon their superiors.

Most of the cases that fall into my 388 were purely mental defects, from fairly low grades to morons, while others on

* Thomas W. Salmon, "Care and Treatment of Mental Diseases and War Neuroses in the British Army," *Mental Hygiene*, 1917.

† H. H. Goddard, "Place of Intelligence in Modern Warfare," *U.S. Naval Medical Bulletin*, July, 1917.

this basis showed slight superimposed psychotic symptoms. Some amount of confusion with memory defect was perhaps the commonest type met with, but transient excitements, depressions, and delusional states were met with as well. In nearly all these latter instances the removal from the active service environment into simple adaptable surroundings saw a more or less rapid return to their normal condition.

As has already been referred to in a previous chapter, dementia præcox not infrequently complicated the picture. It can be readily understood that, without a history of the previous condition in civil life, a mild hebephrenic state could easily be overlooked and regarded merely as the natural dulness and apathy of a developmental defect. There was no reason to think that superimposed psychoses ran a different course in the feeble-minded, or that any specific psychoses could be attributed to them. A certain number, of course, had a history of past epilepsy, or suffered from epileptic attacks as well as their mental deficiency. The epileptic psychoses themselves will be considered later.

If the mental defect does not somehow find his way into the wards of a mental hospital, he can frequently be found among the delinquents for various infractions of discipline. So many of them are continually punished, and it is only when it is found that punishment acts in no way as a deterrent that their officer suspects some developmental defect, and passes the man on for expert advice, when the lack of responsibility is quickly detected. Crimes of all sorts are perpetrated, but with the vast number they consist of the minor offences of not being clean, being late or absent on parade, losing equipment, etc.

Among the psychopathic symptoms frequently manifested by the feeble-minded is that of the "fugue." These fugues were fairly commonly met with in various types of soldiers, but in the mental defect they were decidedly marked. The wandering spell would usually only last for some hours, when the soldier would find himself far away from his unit in more or less a dazed condition and complaining of pains in the head. The recollection of what had happened varied much with different individuals. Complete amnesia might have existed, or a confused, dreamy memory of the intervening

period was admitted. Many were court-martialled for such "desertion," and often punished before it was seen that the act was an irresponsible one. The question of amnesia and amnesic fugues will be spoken of again in a later chapter.

Let me now illustrate some of the main factors involved in mental deficiency by quoting some cases. The first one shows how a palpably inefficient man was recruited, and *notwithstanding his uselessness in England was sent abroad*, only to be returned at an early date.

Case 18.—Private C. D., *æt.* 21 years, was admitted to Netley from Egypt labelled "Imbecility," and with this history: "As a recruit in England it was impossible to teach him anything. He has been a constant source of trouble, would never get up or think of washing unless reminded. Impossible to put on sentry or patrol duty, as the other men refused to go with him. He is dull, stupid, and behaves like an imbecile. Cannot give an account of his service."

On Examination.—In civil life he was a wine-bottler. Says that two years ago he was depressed and sleepless for about a month, but can throw no light on why he should have become so. The family history reveals no psychopathic disorder. He enlisted in November, 1916, did not like the army, and could not get on with the training or with his comrades. He has always been accustomed to keep to himself, and did not like any society. Has not been under fire. States he does not feel fit, and he is found to be depressed, solitary, unoccupied, answering slowly, and is decidedly inaccessible. It is difficult to get any history out of him, but he says he is worrying because he has lost his memory. He takes little interest in his surroundings, and his attention is poor. The memory and orientation are fair. No delusions or hallucinations are discovered. There is slight tremor of the outstretched fingers, tendon reflexes are hyperactive, pupils normal, but a tendency to flexibilitas cerea is shown. Physical nutrition good. Appetite fair, but sleeps poorly.

As may be suspected from the above, the diagnosis was not imbecility, and further observation proved the case to be one of dementia præcox, and eventually he was transferred to a civil asylum. There is excellent reason for thinking that he should never have been recruited, but his transference over-

seas after his uselessness at home (which should have raised the suspicion that mental examination was necessary) was a grave fault in organization. The next case speaks for itself.

CASE 19.—Private F. J., *æt.* 21 years, was admitted to Netley from France labelled "Imbecility," and with the history that "he had been mentally defective, dull, and stupid, was incapable of looking after himself, and useless as a soldier."

On Examination.—In civil life he was a labourer earning 20s. a week. He had a much-neglected childhood; his father went abroad when he was very young, and his mother was "taken away" on account of drink. He was therefore put in the Union Workhouse, and *then in the imbecile ward of an asylum, where he was for thirteen years.* When war broke out he was discharged and enlisted! He has been under fire, and he says the shelling made him very nervous and shaky. He cannot tell me how long he has been in the army or how long he was in France. Complains of nothing. He is correctly orientated for time and place, but cannot tell the year of his birth, who is the King of England, is quite unable to do simple arithmetical calculations, and makes mistakes in repeating the months of the year. He is a mental defect of a low grade. Physically he has a high narrow palate, a low forehead, and a prominent jaw.

A similar case which showed marked microcephaly *was enlisted from an institution for mentally defective children, where he had been an inmate for eleven years!* Though so evidently deficient he was allowed to go to France, where he managed to stay for one month before being returned, as he could not work without supervision, was unable to look after himself, and required proper care and control.

The following also requires no comment:

CASE 20.—Private J. H., *æt.* 22 years, was admitted to "D" Block from France labelled "Congenital mental deficiency." His history stated: "He has given continued trouble while in the army. Always getting lost and losing his equipment. Wandered about all one night. Seems to have very little intelligence. Has no idea where he is or what his regiment is. Cries when spoken to, and is restless and suspicious of everyone. Quite useless for any work."

On Examination.—Says he has never been well since birth, and he never could do anything with his head. Did not get on well at school; it turned his head, and he realizes that his head is not right. Does not know what standard he was in at school. Cannot read or write. *He enlisted ten days ago, and was in France for one day!* Says they sent him back because he was no good in the army. He is disorientated for time and place, is highly mentally deficient, and can give no rational account of himself. He has many physical stigmata of degeneration.

Unfortunately, the lessons that should have been learnt from the recruiting of an unadaptable mental defect were often not taken to heart, with the result that he more than once found his way into the ranks of the army again after rejection on medical grounds. The next case illustrates this.

Case 21.—Private T. M., *æt.* 21 years, was admitted to "D" Block as "feeble-minded," with the history that *he had been discharged twice before as unlikely to become an efficient soldier on medical grounds.* He had a long list of purposeless offences against him, was incapable of doing routine work or obeying orders.

On Examination.—In civil life he used to sell newspapers in the street. He had a history of "forgetting himself" for a few seconds at a time (? petit mal), and he lost his senses if he touched beer and got excited. He had previously been in "D" Block in January, 1916, and discharged the Service to the care of friends on account of mental deficiency. He was recalled in July, 1916, and again discharged. Once more called up in August, 1916, when he found himself in hospital very soon because of his purposeless offences. Being under fire made him specially nervous. He was in a low standard at school, and cannot read or write. In civil life he could never stick at one job for long. He is talkative, childish, excitable, and his intelligence is of a low order. His ideas are few and his general knowledge poor.

That many mental defectives are artful and show a certain subtlety is well known. The following case towards the end of his army career made the most of his previous experiences in being discharged as unfit, and played the game accordingly and with success.

Case 22.—Private C. H., *æt.* 21 years, was admitted to Netley from France with the history that "he had been unable to do anything for himself, not even washing. He had to be led to the latrine, his manner was vague, and he collected rubbish. He was dull, stupid, and said to be of defective intelligence. Had been twice previously discharged from the army after serving a few weeks."

On Examination.—In civil life he said he was a typist, and had always had good health. Nothing abnormal in the family history could be traced, and there was no history of venereal disease or alcoholic excess. He enlisted in April, 1915, and as he was so backward in learning his drill and transparently of so little use to the Service he was discharged in May of the same year as unfit. He re-enlisted in May, 1916, but was again discharged as mentally deficient in the following July. Once more he was made to join up in June, 1917, and sent out to France in a Labour Battalion, but at no time was he under fire. This time in France he took a special dislike to the Service, and states that he "played up" to get out of it. He says he could have worked and looked after himself if he had wanted to, but he wanted to get home, and so put on the signs and symptoms noted above. He is obviously a mental defect with many stigmata of degeneration, but has a certain amount of cunning. He is dull, fidgety, and shows a very low standard of intelligence. He left school at the age of fifteen years, but only reached the third standard. His physical health is good and he acts rationally.

I have already drawn attention to the fact that the mentally deficient are very liable to attacks of wandering, easily getting into a dazed and confused state, which leads to a fugue of which for a time they are quite unconscious. In the majority of instances this involves a court-martial for desertion, and doubtless many are thus punished before their irresponsibility is recognized. The following case illustrates this.

Case 23.—Private A. G., *æt.* 19 years, was admitted to Netley from France with the history that "he had been brought before a court-martial on a charge of desertion, and passed unfit to take his trial by reason of insanity. The Adjutant-General ordered his evacuation to the Base as a soldier under arrest, to be kept under observation for a month, and then

brought before a Medical Board, or boarded at once if not likely to be fit for duty before that time. At the Mental Hospital he was noted as degenerate and simple. He answered slowly, had very little interest in his surroundings, and did not realize the gravity of his position. He was regarded as congenitally mentally deficient and transferred to England.

On Examination.—In civil life he was a labourer in some brickworks. When young he was never very strong, had a good deal of illness, and so had done very little schooling. He is unable to read or write, and shows a deplorable lack of everyday knowledge. He is very dull and stupid, and undoubtedly is a low-grade defective. He earned 23s. in civil life, which he gave to his mother, who allowed him eighteen pence a week pocket-money. He left school when in Standard III. Does not know the year or even the name of the King of England. Easily gets confused. No superimposed psychotic symptoms found. Says he enlisted eight months ago, but could never do any proper training and had never handled a rifle. He went to France, where he was put on digging work, and often under shell fire, which gave him headaches and made him frightened and sleepless, till finally he got muddled, lost his head, and wandered away unconsciously. He now feels quite well and complains of nothing. Very shortly he was discharged the Service.

It will be well here to make my few comments on the *psychopathic inferior*, a term, for many reasons, vastly to be preferred to the usual connotation "moral imbecile." I had to place 1·3 per cent. under this heading. Some authors have included these in their mental deficiency group. Such a procedure can hardly be justified scientifically, for though the psychopath may have, and often does have, some intellectual defect, this is by no means necessary, and the main feature of this type of individual lies in the emotional sphere rather than the intellectual. It is by no means easy for the psychiatrist to be sure that he is dealing with this type of abnormal individual. With the defective there are a number of well-recognized criteria which enable us to diagnose the condition, but with the psychopathic inferior the case is different, and we have to depend largely on a study of the life-history and see how in the past he reacted to the various environmental

stimuli with which he was brought in contact. The psychopathic inferior shows a marked suggestibility and emotional instability, so that his inhibitions to the control of his various instinctive impulses are much lessened, and abnormal conduct in some form or other is manifested early in his life's career. The majority show in childhood and early boyhood unmistakable signs of a disordered personality, and thus tend to be enrolled among the delinquents in school life and after. They are often greatly misunderstood, and find little sympathy handed out to them, so that antisocial habits of thought and action tend to arise, grow, and become habitual. A fair percentage of such individuals find themselves in conflict with the law and in prison. Recognition of these types, an increased study of them, educative factors on a more understanding basis, will in the future, it is hoped, do much on the preventive side both for the good of the sufferer and society as a whole.

It is not to be wondered at that, under the stress of army life, with its rigid discipline and the necessary emotional conflicts that must be faced, the psychopathically inferior should show abnormal reactions. If in civil life he be usually misunderstood, how much more must he be so in the Service during war, when stress of circumstances obviate any but superficial judgment? Untold punishment, therefore, became the lot of these individuals, until perhaps at last some special irrationality was shown which seemed to bring the soldier within the psychiatric sphere. The following case illustrates this well.

Case 24.—Driver C. W., *æt.* 31 years, was admitted to Netley labelled "Criminal imbecile." He had the following history from France: "He is of a low type, changeable, easily upset, when he becomes excitable, refuses to work, and becomes threatening. He very quickly forgets these incidents, but they recur again and again. At other times he becomes depressed over trivial happenings. He has been charged with theft, and since he has lost flesh, become depressed, and thought of suicide. He is irritable and asocial, and has mild persecutory ideas. Feels that the police are always trying to get him. Is an excellent worker."

On Examination.—In civil life he was a fitter and turner, and says he was always in excellent health, though he was once

in an asylum for two years. Though he denies he was in any way insane then, he admits he gave way to furious attacks of anger. He had been in prison various times in civil life, and was never able to keep a situation long. His father is a drunkard, his mother is in an asylum, a sister is in a reformatory, and another brother and sister drink to excess. He first enlisted in the army in 1903, but was discharged in 1905 as unfit, but he states with a good character (?). He re-enlisted in November, 1916, and went to France in January, 1917, where he was much under fire, but not wounded at any time. He says he kept in good health, but was taken to a mental ward because he had a fight with a Frenchman. He strenuously denies that there has been anything wrong with his mind, but he confirms all the statements made about him overseas, and realizes that he gets upset very easily. He answers readily and rationally, and no symptoms of any definite psychosis are found. It is evident, though, that he lacks inhibition, and is highly unstable and psychopathic. His physical condition is excellent. From the War Mental Hospital he was transferred to he was finally sent to an asylum. Many others of a like nature could be quoted, but no useful purpose would be served by so doing. Doubtless, had I had the opportunity of studying the life-histories more and in greater detail, the percentage of psychopathic inferiors would have materially increased.

CHAPTER XI

GENERAL PARESIS

THE more psychiatrists see of general paresis, the more they find that the diagnosis depends upon a study of the mental symptoms and the organic signs, plus the blood and cerebro-spinal fluid examination. Even then one has to be very wary in the differentiation from cerebral syphilis, and some observers would go so far as to state that one can never be certain until microscopy has revealed the pathological changes as laid down by Nissl and Alzheimer. Macfie Campbell has shown in some published cases how comparatively easily diagnostic mistakes may be made, and that a positive finding in the blood and cerebro-spinal fluid with the Wassermann test by no means gives us the right to label the case paretic, though thereby the disease is rendered the more likely. With such difficulties to face, it was by no means possible for me to be in any way sure how many cases were passing through " D " Block, and it was later found that a good many wrong conjectures had been made when the cases were afterwards followed up. It is always a disease the commencing symptoms of which show themselves in various forms. These were often vague, and the physical signs at times hardly noticeable. Characterological changes were often in evidence, besides the irregular performance of duties, breaches of discipline, as well as more serious offences. Now and again the typical textbook case would present itself with its euphoria, grandiose and grotesque delusions, and with the physical signs of pupillary disorders, tremors, speech and gait defects, and tendon reflex alterations. It was surprising to note at times how fully formed the disease became after conduct had become sufficiently disordered to draw the attention of others, and on active service such abnormalities could not be disguised for long. Chavigny* thinks that the paretic in war-time, more than in time of peace,

* Paul Chavigny, " Psychiatry in the Army," *Paris Médical*, October, 1915.

evinces maniacal excited states. My experience in no way confirms this. Though now there is no longer any dispute as to the syphilitic origin of general paresis, and we can no longer look upon it scientifically as a parasyphilitic manifestation, since the spirochæte has been definitely found in the cerebral lesion, there is still obscurity as to the factor which differentiates the disease from ordinary cerebral syphilis, and which seems to have relation with the long incubation period. The great variations in its prevalence in different races has rather forced the opinion that the difference in susceptibility to paresis must be looked for in the differences in the individuals rather than in any difference in the quality of the syphilitic virus. The question then arises whether the conditions of warfare have in any way thrown any light on the subject. Has the stress and strain of active service brought about an increased incidence of the disease ? Do the symptoms evolve more quickly in such circumstances ?

Out of my 3,000 cases, 142 were cases of general paresis, a percentage of 4·7, a distinctly lower figure than is met with in civilian life, but it must not be forgotten that in the British Army we are dealing with individuals mainly between the ages of eighteen to forty, whereas the disease usually manifests itself between the ages of thirty-five and forty-five years. Among the civilian male population the percentage is about 11, and European armies show an average of about 7 per cent. during peace-time. During the Russo-Japanese War the Russians showed a percentage of 5·6. William White,* in commenting on this, thinks it seems evident that the development of general paresis must have been hastened by war conditions, which conclusion he deems is borne out and re-enforced by the further fact that in the soldiers from the front who were under treatment there was evidence of syphilis in 20 per cent., while among other soldiers under treatment evidences of syphilis were present in only 1·6 per cent.

Hotchkiss, in his analysis of cases at Dykebar War Hospital, found only 2 per cent., and definitely states that the data on these cases do not justify an opinion on the part played by military service in bringing on the disease in the syphilitics.

* William A. White, "Applications of Psychiatry to Certain Military Problems," *U.S. Naval Medical Bulletin*, January, 1914.

In earlier days of the war Bonhoeffer's statistics showed 6 per cent. paretics, Meyer 3·5 per cent., and Hahn only 3 per cent. in the German Army. Eager, of the Lord Derby War Hospital, found his paretics were 4·6 per cent. of his admissions, and hence on a par with my results. It seems, therefore, from our results, that we have no ground for supposing that the conditions of warfare increase the actual number of cases, but the age incidence perhaps tends often to be somewhat earlier, which points in the direction of the incubation period being shortened. Since the infection itself often was denied, or the date thereof uncertain, it was not possible to be sure of how long this incubation was. Out of the 142 cases, 10 were under thirty years of age, the lowest being twenty-seven years; 20 were thirty-five or under, and 31 were under forty years. When once developed, the disease certainly seemed to progress more rapidly than in civil life in many cases, and at times the disorder developed in quite a fulminating way. Mariet and Durante,* from experiments on rabbits with violent shell explosions, brought about cerebral changes which they think accounts for the galloping course of general paresis after concussion from an exploding large shell. The three societies for mental diseases in Paris—viz., Société Clinique de Médecine Mental, Société Medico-Psychologique, and the Société de Psychiatrie—held joint meetings in 1917 to discuss the relation of general paralysis to warfare and the compensation such sufferers should obtain. Dr. Pactet there stated that the non-recognition of liberality towards such cases was due to the belief that general paralysis is exclusively syphilitic in its origin, but to be syphilitic was not enough to bring on general paralysis. He asked if anyone could affirm that the fatigue, the emotions, the dangers of the war do not play a part in localizing, aggravating, and accelerating the production of the meningo-encephalitis? He thought that in each individual case the effort should be made to estimate the part for which the circumstances of war were responsible, and if the conditions seem to have been influenced by the data produced, the soldier should be treated generously. This, I think, is the only just and scientific attitude to adopt, con-

* Mariet and Durante, "Experimental Shell Shock," *Presse Médical*, Paris, August, 1917.

sidering we are so largely ignorant as to the secondary factors in the development of the disease. In an endeavour to trace some special factor in active service which may have contributed in some way to the advent of the disease I studied my cases in vain, but my opportunities for research on this point were meagre, and I unfortunately had to rely on very superficial data.

Alcohol for many years has been under suspicion as being causally related, but one is tempted to reflect on the manifold diseases to which alcohol has not in some way been ascribed in the past. Among my 142 cases I cannot find that alcohol has been at all prevalent in their history either in army or civil life, and in a good few where this factor was present it seemed to have been a symptom and not in any way causal. Kraepelin suggests that perhaps the general deterioration in the health of the race through alcoholic intemperance, still more than the personal alcoholic habit, may increase the susceptibility to paresis. Worry, emotional stress, and a functional overstrain of the cerebral cortex have long been regarded as likely contributory agents, and these are such as are met with in warfare in abundance. But if such agents have the power to enhance the development of paresis, it is surprising that the percentage of such cases is so low. Though some of my cases had an indefinite history of shell shock, none suffered from any special traumata to the head, which have been regarded by some as determining influences. It seems, therefore, not only from my own findings, but from a study of current literature, that the late war experiences have not in any way added to our pathological knowledge of the disease. Not a few of the cases were comparatively abrupt in onset, showed anomalous symptoms, and were only correctly diagnosed after prolonged observation and serological examination. The following case is an illustration of this:

Case 25.—Private S. N., *æt.* 31 years, was admitted to Netley from France with the history that he was worried and agitated, and believed he had got something alive in him, probably a snake. He described it as round, flabby, and with a tail. He said it was in his stomach yesterday, but it had got up into his throat and was choking him. He had torn his tonsils in trying to get it out, and was constantly squeezing

his larynx to push it out. Some girl telephones to him saying, "You're dying; it's eating your lungs."

On Examination.—In civil life he was a barman. States that his left arm and leg are somewhat weak, that they have always been so, and that he was rejected five times for the army. At times he has been dizzy, had headaches, and was sleepless. He denies contracting syphilis and any alcoholic excess. Thinks he had a paternal uncle in an asylum. He enlisted in August, 1917, and went to France the same month in a Labour Battalion. He has been road-making most of the time, and has done so under shell fire, which made him very nervous. Four months later he says he was put in hospital because of the snake inside him. He is very dull, depressed, and deluded, but at present has no hallucinations. Has no insight into his condition. Conversation is very irrational. States the snake squealed when it was in his throat, and he felt as though he were dying, but he thinks they must have got it out of him at the hospital. Tells me that a woman's voice talked to him, saying there was something in his throat and that he was poisoned. His wife was put in irons and placed in the next bed to him in hospital. He answers fairly readily, and his memory and orientation are not at fault. Physically he is in moderate health. No weakness of his arm and leg are found. There is some tremor of the outstretched fingers, the tendon reflexes are active, and the pupillary reactions normal.

His history of weakness of an arm and leg on one side with headaches and dizziness suggest some early syphilitic cerebral lesion. An examination of his blood and cerebro-spinal fluid and prolonged study proved finally that the case was one of general paresis.

In a few the onset was particularly acute, so that the inaccessibility and difficulty in physical examination rendered the diagnosis uncertain for some time. In one fulminating case the diagnosis was only established post mortem. In the case with the low age of twenty-seven years an abnormal condition seemed to have started after a heavy bombardment, and signs pointing to his being a paretic manifested themselves nearly two years later. The outline of this case is as follows:

Case 26.—Private J. P. S., *æt.* 27 years, was admitted to Netley with the following history: "After a heavy bombard-

ment in May, 1915, he was reported to have been generally nervous and to have talked to himself on and off for some time. In June, 1916, he went to the Base for dental treatment, and he was then more nervous and seemed strange, but evidently no special attention was paid to this. In December, 1916, he went home on leave and got married. On his return it is said that he told several of his comrades that his wife was unfaithful to him. Nevertheless it was not until the following March that he was sent sick because he was tremulous and emotional when spoken to, often gazed vacantly about him, and muttered to himself. He became dull, somewhat confused, wandered in his conversation, and was suspicious. He stated that his unit wanted to get rid of him, made insulting remarks about him, and accused him of leading a fast life. He showed tremor of the lower facial muscles and tongue, his deep reflexes were very brisk, there was slight Rombergism, the gait was somewhat spastic and ataxic, and his pupils reacted poorly to light."

On Examination (*April*, 1917).—In civil life he was a silversmith, and he had seemingly always had good health before enlistment. Nothing specially abnormal was found in his own past history or in that of his family. He denied any syphilitic infection, and nothing pointed to any past alcoholic excess. He enlisted in September, 1914, got on well with his training, and was sent to France March, 1915. He was much under fire, but was not as far as he knows upset by it, and was not wounded at any time. He has no insight into his condition, and denies that there has been anything the matter with him except for some pains in his legs for which he says he was sent into hospital. He is dull and stupid, and does not readily comprehend the questions asked him. Gives a poor account of his past, and thinks he is still in France, though fairly orientated in time. Says he is somewhat depressed, but that is because another man is living with his wife. There is marked tremor of his face around his mouth, and slightly in his tongue and outstretched fingers. Gait somewhat unsteady and the speech of a slurring type. On further observation at a War Mental Hospital and serological examination general paresis was diagnosed, and he was transferred to a civil asylum.

CHAPTER XII

ALCOHOLIC PSYCHOSES

THE question of alcohol in its relation to mental disease has been already largely dealt with in the chapter on Psychiatric Considerations, and when paranoid reactions were discussed. I have there put forward the view that alcohol, scientifically speaking, is much more contributory than causative, that in so many of the so-called alcoholic psychoses no toxic organic signs are manifested, and that precisely similar syndromes may occur without the alcoholic factor having been present. Our past materialistic outlook in psychiatry had led us to look for simple and superficial ætiological factors without searching any farther, but now that so much psychological insight has been gained into the deeper human trends and the conflicts to which the mind is so prone, there is less excuse for our pathology being so shallow. Many psychiatrists think that where a psychotic state develops after excessive drinking, they have every right to regard the alcohol as mainly provocative and to term it an alcoholic psychosis, averring that the abnormal condition would not have arisen without it. At any rate, they cannot point to any fact showing that the alcohol acted in any other way than *psychologically*, and such mental disorders should be classified separately from those which are patently toxic, such as delirium tremens, pathological drunkenness, alcoholic confusion and dementia, and Korsakow's polyneuritic psychosis. These evidently stand in quite a different category. Recent work by Stocker points to the fact that alcohol only produces acute insanity, and he has shown that the chronic forms of so-called alcoholic insanity should really come under the heading of dementia præcox, epilepsy, etc., these being coloured by the factor of alcoholism. Mott's statements, too, confirm this when he observes that liver cirrhosis is very rare in asylums, wherefore it follows

that the majority of people will tolerate large quantities of alcohol, and suffer thereby from physical disease, without incurring any mental disorder, which latter will only take place where other important factors are present.

The psychology of alcohol is now beginning to force its importance upon us, and psychiatrists would do well to recognize its importance. I think it was Matthew Arnold who many years ago drew attention to its great use in promoting the social instincts of mankind, and by so doing it undoubtedly tends to aid man's adaptation to his environment. Alcohol narcotizes the petty worries of life when taken in moderation, and banishes, temporarily any way, many mental conflicts that would otherwise bring mental pain. Those who take alcohol habitually to excess have probably sterner conflicts to face, which consciousness strives with all its might to prevent the individual from becoming aware of. It may be that with the aid of alcohol mechanisms are brought into play which achieve their purpose of banishing the truth from consciousness, but at the expense of sanity. The commonest mechanism in chronic cases is that of projection, whereby the individual projects upon the outer world that which his own ego repudiates. Self-reproach is thereby evaded and a paranoid state built up. One can show in other alcoholic states how the use of this drug has its compensatory action. Trotter* on this theme says: "Alcoholism, almost universally regarded as either, on the one hand, a sin or vice, or, on the other hand, as a disease, there can be little doubt that in fact it is essentially a response to a psychological necessity. In the tragic conflict between what he has been taught to desire and what he is allowed to get man has found in alcohol, as he has found in certain other drugs, a sinister but effective peacemaker, a means of securing, for however short a time, some way out of the prison-house of reality back to the Golden Age. There can be equally little doubt that it is but a comparatively small proportion of the victims of conflict who find a solace in alcohol. The prevalence of alcoholism and the punishments entailed by the use of the remedy cannot fail to impress upon us how great must be the number of those

* Wilfred Trotter, "Instincts of the Herd in Peace and War," Fisher Unwin.

whose need was just as great, but who were too ignorant, too cowardly, or perhaps too brave to find a release there." If only social workers, politicians, philanthropists, as well as psychiatrists, would look upon the alcoholic question more in this psychological light, much greater good might accrue to society and mental medicine.

The studies of Bevan Lewis showed the relationship existing between poverty, want, anxiety, and associated moral factors and mental derangement, and made a claim of dissociation of alcohol and insanity. He found that the least intemperate communities had the highest rate of pauperism and insanity, while the most intemperate communities had the lowest rate of pauperism and insanity. That is, when prosperity was greatest and funds for intemperance were available, poverty and mental stress were least and insanity was less prevalent.

Reserving under this heading, then, purely the definitely *toxic* alcoholic cases, I find only 1·6 per cent., which stands in great contrast to the results found by other observers, and peculiarly so compared with the figures spoken of by French alienists. I am fully aware, though, that there may have been very temporary cases which soon recovered and were returned to duty forthwith. My figures, of course, only refer to those cases who were invalided home. Considering the prognosis, it would usually not be politic to send such to England unless complicating sequelæ were in evidence. Meyer* states that in the German Army chronic alcoholism showed itself early in the war, and such men hampered the Service by irritability or apathy, periods of intoxication, epileptiform states, and states of mental confusion in which they would leave their regiment and wander about the country. They exhibited cases of acute alcoholic paranoia with hallucinations connected with some fear caused by the war, such as combat with the Russians, the accusations of being a spy, dread of being accidentally shot by comrades, etc. Acute alcoholic psychoses were especially frequent at the beginning of the war in the German Army. Cimbal,† writing later, states that in his

* E. Meyer, "Psychoses and Neuroses in the Army during the War," *Deutsche med. Woch.*, December, 1914.

† W. Cimbal, "Psychoses and Psychoneuroses in the Ninth Army Corps since Mobilization," *Die Seelischen und Nervösen Erkrankungen, Neurol. Centrabl.*, Leipsic, June, 1915.

experience alcoholic psychoses were comparatively rare. Saaler* seems also to regard alcohol among the German soldiers in a less important light, for he says he was surprised by the resistance shown by the alcoholics. I have previously mentioned that Lepine places on record that alcohol was the primary and sole cause in one-third of his mental cases, and more than half, perhaps two-thirds, were influenced by it. He is backed up in this respect by his French colleague Hoven,† who says that in some material, alcoholism, whether as effect or cause of predisposition, was present in a third of all cases. Löwy‡ regarded it as remarkable that among a thousand soldiers who habitually used alcohol in moderate and sometimes larger quantities there was not a single case of delirium tremens after several weeks of total abstinence, in spite of the presence of predisposing factors, and he thought that fresh air and vigorous exercise seemed to offset somewhat the effects of predisposition. As far as I can find, no observer has attributed any harm to the ordinary rum ration served out to the British troops. Most officers speak of its beneficial action, while the larger tot given to the men just prior to "going over the top" must have been in most cases a boon if not a necessity. Hotchkiss, of Dykebar War Hospital, finds, out of his 831 oversea cases, 18 per cent. suffering from alcoholic insanity! He states regarding them: "This group includes all the varieties of symptoms found in this form of mental disease, and in all the cases a reliable history of chronic alcoholism or bouts of drinking was obtained, and care was taken to exclude cases of mental deficiency in which the tendency to alcoholism was one of the symptoms. There were many cases of delirium tremens, the most common history being that the patients had been home on leave from the front and had been having, as they put it, 'a high old time,' but on returning to France they showed more susceptibility to the horrors of war, and often, after a few days, had to be sent back suffering from well-marked delirium tremens.

* B. Saaler, "Relation of Nervous and Psychic Affections to Military Service," *Berlin. klin. Woch.*, December, 1916.

† Hoven, "Mental Diseases and the War," *Archiv. méd. Belges*, Paris, May, 1917.

‡ Max Löwy, "Neurological and Psychiatrical Observations on the War," *Monat. für Psych. u. Neurol.*, Berlin, 1915.

There seem to be two types of this class according to their history—one who broke down as soon as the supply of alcohol was cut off on going aboard the leave boat, the other who showed no signs till again in the firing line. Those in the latter class were affected by shell fire, etc., in a way not previously felt by them, and they rapidly became nervous, sleepless, and developed hallucinations. In sharp contrast to these cases of delirium tremens were the chronic delusional states, many of whom were comparatively elderly men who had been stationed at the Base, and thus had more opportunity for drinking. Between these two classes were those who showed various symptoms, as confusion, depression, subacute excitement, and in practically all cases hallucinations. The history of many of these cases suggested that though alcoholism was a prominent feature in predisposing to a mental breakdown, of still greater importance was the strain and stress of the campaign, and had it not been for this the breakdown would either never have occurred or would have been postponed."

In answer to these findings I can only state that I saw no evidence of these many cases of delirium tremens in 1917 among my much larger number of soldiers. It is true that a certain number had broken down very soon after having had a leave, some of whom on that occasion had imbibed too freely and others not, but I aver that the factor mainly causative in the breakdown was certain mental conflicts connected with domestic worry brought home to them while on leave, and not the alcohol with which some of them endeavoured to drown the trouble. The discovery that the wife had been unfaithful, the possible finding of an illegitimate child, illness of someone near and dear, coupled with the dire fact that swift return to the battlefield was imminent and imperative—these were the psychogenic factors that lay at the root of the psychopathic disorder to follow. Case 7 in my chapter on paranoid states illustrates my point exactly. This soldier had often been crimed for drink while in the army, and he frankly admits that he drank freely when on leave shortly before the outbreak of his psychosis, but he did so because he was so worried, as he had found his wife unfaithful. It was this psychic factor which tended to render him psychotic.

He had drunk as much many times before, but retained his mental health when no special mental conflict was present. Case 8 still more confirms my point of view. Here again the psychosis developed after a leave fraught with personal worries—the death of his father and the enforced leaving of an invalid mother—and in this case no alcoholic history was traceable, though the clinical syndrome was very similar in many respects. To roughly include all these cases under the term "alcoholic psychoses" is clearly hardly defensible. Hotchkiss himself suggests that in many cases the factors of stress and strain in the campaign were of greater import than the alcohol, and I suggest that if, instead of using such vague terms as "stress and strain," we take the trouble to look for something more specific, we shall without undue difficulty find evidence of some mental conflict to which the individual has maladjusted.

In curious contrast to Hotchkiss's figures, Eager, of the Lord Derby War Hospital, out of his 1,652 oversea cases, only labels just over 1 per cent. as alcoholic insanity, and remarks thereon that the small percentage of alcoholic cases reflects very great credit on the abstinence of our army in the field! I do not know whether his views on these cases coincide with my own or not, but our statistical results are similar. All this diversity of classificatory findings shows the enormous importance of British psychiatry coming to some more scientific and mutual understanding on these points. It hardly needs mentioning that those who were feeble-minded or psychopathic inferiors, and those who had sustained head injuries, showed themselves markedly intolerant of alcohol, and it is also a moot point whether under the influence of warfare smaller doses than usual may not be apt to cause psychic troubles. It is said, too, by observers in tropical regions that a very small amount of alcohol rapidly produces a most pernicious effect on those who have previously suffered from sunstroke. Those who developed various psychoses frequently presented a history of alcoholic delinquencies among their early symptoms of mental instability. My cases included only very few who could have been considered as delirium tremens, and on admission had only nervous sequelæ with some remaining toxic signs. It seems much more feasible that

such cases should be treated abroad and not sent home. Some evinced an alcoholic confusion, others temporary excited states, and some old drink habitués presented a demential condition not always easily differentiated from general paresis. Two men showed the Korsakow's syndrome well who had a long alcoholic history. The next case is an example of this.

Case 27.—Private G. T., *æt.* 35 years, was admitted to Netley from Salonika with the history that " he was admitted into hospital because he showed confusional symptoms, had auditory hallucinations, and showed great loss of memory, not being able to give his regiment or number. He complained mainly of headache, and said that he had injured his head on board ship. His hallucinations seemed to leave him, but his confusion and memory loss continued."

On Examination.—He said he was a coal porter in civil life, and had always had good health before. He is a heavy man with a large bloated face and an enlarged and flabby abdomen. He can hardly give me any account of himself. States he feels quite well, but realizes that his memory is much at fault. He cannot recollect when he enlisted or when he went abroad, but thinks his memory was affected somewhat when he joined up. Gets occasional headaches. Knows he is in a hospital, but has no idea where or what month or year it is. Has a hazy idea he has been to Salonika, but I fancy this was mainly suggested to him. Tells me a good deal about his remote past, and confesses to having drunk freely for some years. Memory retention is extremely poor, but no confabulation is seen. Says he is quite happy, and he laughs childishly at trivialities. Sleep is rather poor, but his appetite fair. He is quiet and well behaved, and no delusions or hallucinations were discovered. There is fine tremor of the tongue and hands. Knee-jerks cannot be elicited. Calf muscles distinctly tender on pressure, and motor power in legs poor. Cranial nerves normal, and also the pupillary reactions. Later he developed some delusional formation, did not improve, and was eventually transferred to a civil asylum from the War Mental Hospital.

There were one or two cases who had manifested periodic outbursts of drinking, seemingly of a dipsomanic type. With

the limited time at my disposal for the study of individual cases I could not investigate the life-history sufficiently to be at all sure of their psychopathological basis. This recurrent uncontrollable desire for drink, according to Kraepelin and Gaupp, is closely related to epilepsy, while Ziehen believes, though some dipsomaniacs are of an epileptic nature, others should be placed in the category of periodic melancholia and mania. Here again we see the pity of regarding such conditions as disease entities and the necessity of fitting them into some recognized nosological pigeon-hole. Juliusburger,* from the psycho-analytic standpoint, looks deeper, and holds that dipsomania is a peculiar mental state with an underlying psychosexual mechanism, and reports analyses of cases in support of his view.

This point brings one, in conclusion, to bring forward again the question of a latent homosexuality being aroused in the army through the long and intimate sole companionship of large masses of men. I have already mentioned in a previous chapter that it has been suggested that a homosexual impulse may at times be an unconscious incentive to a man's enlistment in the army, and later I made the suggestion that the prevalence of paranoid states found in the psychoses of war also may have their psychopathological basis in the same sphere. What of its relation to alcohol? The psycho-analytic school have found that an intimate relationship exists between homosexuality, alcoholism, and drug-taking. According to Abraham, craving for alcoholic beverages abolishes more or less the sublimation of the homosexual activity, and it is therefore interesting to inquire whether or not the unconscious homosexual activity is capable of stimulating the craving for alcohol. There are indeed good grounds for believing that such is the case, for no impulse as the homosexual one is held in such abhorrence by the male mind, and the taking of a narcotic drug such as alcohol to still the unconscious desire is a natural sequence. Karpas, of New York, in speaking of the complexity of mental life and its direct relationship to our longings and cravings, which are determined by conscious and unconscious forces, expresses my views when he sums

* Otto Juliusburger, "Contribution to the Psychology of the So-called Dipsomania," *Zentralblatt für Psychoanalyse*, July to August, 1912.

up the essence of these questions in the following words: "Some of our cravings are gratified; others find realization in our dreams; still others are repressed and compensated. In fact, our mental life is nothing but a readjustment of complex reactions. The poet finds recourse to his phantasies; the philosopher to his theoretical speculations; the scientist resorts to his inventions and hypothetical theories; the well-balanced normal individual seeks adjustment in healthy activities—art, literature, science, occupations, sport, etc.; but the individual with a poorly endowed constitution finds refuge in neurosis, psychosis, alcoholism, drugs, and other vicious habits. We must recognize that the alcoholism is nothing but a compensation for a complex the fulfilment of which was denied by reality." The President of the Medico-Psychological Association, in his Presidential Address of July, 1918, quotes Sir Robert Armstrong-Jones, who is stated to have said that if only the evils of alcohol and venereal disease were disposed of, then half the problem of insanity would disappear with them. Would that I could think that this problem could be so disposed of, even partially.

CHAPTER XIII

EPILEPSY AND EPILEPTIC PSYCHOSES

THOUGH epilepsy is probably the main disease that the recruiting authorities have paid much attention to in the history of possible recruits brought before them, 4,782 officers and men were pensioned for this disability from the outbreak of war to November 30, 1918. The victims of this disorder would fall into three groups: (1) Those who had suffered previously to enlistment, but disguised the fact when asked. (2) Those who did not deny previous attacks, but who were nevertheless enrolled and told it would make no difference. (3) Those who developed the condition after enlistment. That an epileptic should not be admitted to the Service few would dispute, and yet, if every possible man of necessity must be brought into the ranks in times of war, one can realize that some epileptics whose attacks are infrequent and whose mental state has not seemingly deteriorated thereby could do some useful work in the Home Forces. Sending such men to the battlefield, where the responsibilities are so great, is, of course, out of the question. The cases that developed in the Service must be looked on with the gravest suspicion as to correctness of diagnosis, and undoubtedly were really psychoneurotic. A large number of medical officers who labelled cases as epileptic had insufficient knowledge of the differentiation from hysteria. Previous to my being in charge of "D" Block I did duty in neurological wards, where all the cases of "convulsions" were admitted under my care, and it soon became evident to me that the numerous patients sent in as epileptic were not so at all, and these largely comprised those who had had no convulsive attacks prior to enlistment.

It has been in the past customary to lay down certain rules as to whether an attack was hysterical or epileptic, and types were often met with which, according to these rules, puzzled

the physician. I do not believe that there is any hard-and-fast line to be drawn between the two diseases in this respect, and that all grades of attacks may be met with, from a typical emotional hysterical attack to the typical epileptic convulsion. Since we are gaining a glimmering into the psychic element in epilepsy, there seems no reason why a definite line can be so drawn. As has been frequently pointed out of late years, the most obvious and really the most inessential part of the disease has been studied almost *ad nauseam—i.e.*, the convulsion itself; whereas the interparoxysmal period, with its patent mental abnormalities, has received comparatively little attention. That the condition hitherto regarded as petit mal should really belong to the psychoneuroses is more and more forced upon us. Ernest Jones,* in a highly stimulating article, states that as a result of our advance in knowledge the modern tendency has been to base the differential diagnosis in doubtful cases upon an investigation of the mental state of the patient during the free interval rather than upon the symptoms displayed in the fit itself. Hoche† has shown that, one after another, the various features that had been advanced as distinguishing an epileptic from a hystero-epileptic fit have been proved to be non-pathognomic, until at present it is definitely known that every symptom of a grand mal fit, from fixed pupils to sphincter relaxation, may occur as well in functional conditions as idiopathic epilepsy, although, of course, the features referred to are more frequent in the latter condition. Heilbronner even goes so far as to refuse to diagnose epilepsy in the absence of the characteristic mental changes found in that condition apart from the fits. Binswanger‡ maintains that there is no sharp dividing-line, as I have already conjectured, and that one state may pass over into the other.

It is true that all neurologists and psychiatrists note the fact that an epileptic has a more or less specific type of character, and they point out his egotism, quarrelsomeness,

* Ernest Jones, "Mechanisms of a Severe Briquet Attack as contrasted with that of Psychasthenic Fits," *Journal of Abnormal Psychology.*

† A. Hoche, "Die differential Diagnose zwischen Epilepsie und Hysterie," Berlin, Hirschwald, 1902.

‡ Otto Binswanger, "Die Hysterie," *Nothnagel's Spec. Path. u. Ther.*, vol. xii., pt. i., Vienna, Holder, 1904.

shallow religiosity, etc.; but the deeper currents of his mentality, his mental conflicts, and the maladapting factors which are so often seen prior to his attacks, have received but scant notice. It is also true that the fits may be replaced by the exhibition of various anomalous psychic phenomena termed "psychic equivalents," but, beyond this being mentioned, little or no light has been thrown on their meaning or mechanism. We are much indebted to Pierce Clark,* of New York, for his clinical studies in epilepsy and for his so ably demonstrating the psychogenetic aspect of this disease. In carefully recorded case-histories he has shown the type of abnormal mental factors that slowly but surely get built up into the epileptic character, and he states that from a minute study of their reactions in early life he can recognize the prospective epileptic, and that by suitable psychotherapeutic measures the disease may be prevented, aborted, or even cured. MacCurdy,† too, has pointed out that the supervening dementia which seems later on to be just as much a part of epilepsy as the convulsions has no real relationship with organic deterioration, but is due to lack of environmental interest and to the giving up of the struggle to make any adaptation at all. He avers that by the arousing of interest the patient's seeming dementia may be relieved and even entirely dissipated. From what I have said elsewhere the reader will see how frankly I lean towards the psychogenetic aspect of so many diseases that come within the purview of the psychiatrist. I have dwelt here upon this view-point because I think it explains many of the epileptic states that arose after enlistment. It is easy to understand that the complex adaptations required of the soldier, who is recruited more or less suddenly from civilian life, may tend to produce mental conflicts, the reaction to which in many may be some anomalous convulsive attack which requires special care and knowledge to understand. It has been far too much the rule to jump to the conclusion at once that the soldier is an epileptic, and discharge him from the army forthwith accompanied by a certain stigma which is so often undeserved.

Pure epilepsy has, in the majority of instances, shown itself

* See articles in *Psychiatric Bulletin*, January and April, 1916, and January and October, 1917.

† See article "Epileptic Dementia," *Psychiatric Bulletin*, July, 1916.

prior to enlistment. Mott* stated that cases which were said to have developed epilepsy as a result of shell shock were, generally speaking, individuals whom it might fairly be assumed were either epileptic or potential epileptics prior to the shock. In the majority of cases I think he is in error, and that most of such cases were certainly psychoneurotic in character. Lieut.-Colonel Hurst, who had a large experience of such patients, stated: "Our conclusion is that the vast majority of, if not all, cases of war epilepsy which have arisen during the war with men who never had fits before are functional, and, being functional, are curable." Other observers do not agree, but they mostly consist of those who either have not had an intimate acquaintance with war cases and their treatment, or lack the knowledge which the modern teachings of psychopathology have made prominent. One, however, does not doubt but that certain cases were definitely traumatic in origin, but such organic forms were few and far between. Eager states that out of a consecutive series of over fifty cases of head injury received in action which he had investigated, in only two instances did he meet with a true traumatic epilepsy. It is also possible, as Lepine points out, that some soldiers who in civil life had *formes frustes*, had only had indispositions at variable intervals which were not recognized as epileptic in character. Such might, of course, blossom forth into patent epileptics in the circumstances of warfare.

It seems fairly accepted that the epileptic previous to enlistment had subsequently more frequent and more severe seizures in consequence of active service. Leppmann, of Berlin, however, states that epilepsy has not made itself noticeable during the war, and so far as he could judge the seizures did not occur more frequently. The German psychiatrists Bonhoeffer, Meyer, and Hahn up to March, 1915, give the percentage of epileptics as 14, 11·5, and 8 respectively. The cases that were admitted to "D" Block, Netley, with the label of "Epilepsy" or "Epileptic insanity" were mainly of two types, one of which showed great violence during and after the attacks,

* F. W. Mott, "Effects of High Explosives upon the Central Nervous System," Lettsomian Lecture, 1916.

and the other manifested a confusional state with fleeting delusions and hallucinations. Together they only amounted to 1·2 per cent. of the 3,000 cases. Cases of epilepsy without special attendant mental symptoms, of course, were drafted into neurological wards. It was, as usual, not uncommon to find that a soldier had been already discharged from the Service because of this defect, but enlisted again or was called up, his previous unfitness being disregarded. Hotchkiss, of the Dykebar War Hospital, found only seven epileptics among his 831 Expeditionary cases. He states concerning them: "With one exception, which was a case of traumatic epilepsy, all the cases had suffered from epileptic fits before enlistment, but, of course, this fact had been concealed. The mental symptoms were chiefly confusion, and three of them had attempted suicide, but had no recollection of the fact. One case was exceedingly irritable and dangerous, and ultimately had to be sent to an asylum; but the other six, after a period of rest, were able to be sent home." Eager's cases at the Lord Derby War Hospital amounted to less than 1 per cent.

In some of my epileptic admissions I have been struck with the prolonged unreasoning violence shown while in an unconscious state. Automatic and seemingly purposeless aggression has been marked, and at times constituted the whole attack. Such observations before have led to the belief that in some way the fit represented emotion of an aggressive type. The psycho-analytic school have of late endeavoured to analyze the mental material that might lead to such an outburst. Jung of Zurich found signs suggesting that the emotional tone in the epileptic was unusually lasting. Stekel* regards the epileptic as a repressed criminal and the convulsion as a substitute for the criminal act. He believes that epilepsy is more often than we have hitherto thought of psychogenic origin, and that there is a strong tendency to criminality which is unbearable to consciousness. One or two cases that came under my care bear this theory out. One especially that I had an opportunity of making a slight psychological analysis of, was of such interest that I will quote the case in full.†

* William Stekel, "Die psychische Behandlung der Epilepsie," *Zentralblatt für Psychoanalyse*, Nos. 5 and 6, vol. i.

† This and another case reported by the author in the *Journal of Abnormal Psychology*, vol. xiii., No. 1, April, 1918.

Case 28.—Private C. J., bandsman, *æt.* 34 years, was admitted to Netley labelled "Epilepsy," and with the following history from France: "He has had epileptic fits, and after a few clonic spasms he becomes maniacal, and once had to be held down for three hours! He says he has had outbreaks like this before. They start quite suddenly, and in the attacks he is injurious to others. He was quite unconscious, and had no recollection of anything afterwards, but is told he has been violent. Later he was perfectly normal."

On admission he was put to bed and kept under special observation in case an attack might suddenly come on, and hence an accurate report obtained of all that occurred. He stated he felt quite well, and during the short time he was here no fit or any other untoward symptom was seen. The fact of his showing special violence at the end of his convulsion and his remaining unconscious such a length of time induced me to inquire carefully into his psychological history, when the following interesting data were brought to light: He was the eldest of sixteen children, and had little or no serious illness with the exception of some of the usual childish ailments. He was specially attached to his mother, who was always very kind and good to him, and his love and dependence on her were all the greater because of the intense severity of his father. His father's treatment of him was so cruel that he spent a very miserable childhood. His father died when he was twenty-two years old. He says that his father was very puritanical, and that every harmless pleasure was suppressed; for any trivial fault he was punished unmercifully, and on one occasion he was laid up for three months because of the brutal thrashings he had received. The father was once had up before a magistrates' court in consequence of the treatment of his son, and was heavily fined. He has a very highly vivid recollection of the intense resentment he felt against his father; this was intensified at times by the friction caused between the parents because of his father's attitude towards him, which brought much misery to his mother. Nevertheless he repressed this resentment because he could not help feeling that his father thought himself to be just, and his upbringing had very early and deeply ingrained into him the idea of the injunction, "Honour thy father and thy mother, that thy days may be long in the land," etc. The first unconscious attack occurred

twelve years ago. Investigation shows that a few months previously he had quarrelled with a friend, and they were starting to fight when his father, who was ill, came into the room to separate them. Without realizing what he was doing, in the heat of the moment he struck his father in the face, causing blood to flow. He has never since been able to forget his father's expression as he said: "My son, I never thought you would do a thing like that." Ever since that event, which was such a psychic trauma to him, he has felt that if ever he meets with the victim of his original quarrel through whom he hit his father he will kill him if possible and swing for him. "It's me or him." Two days after this incident his father died of pneumonia. For many months the patient suffered from great depression and insomnia, and ever since has had a recurrent dream in which he sees his father with a contused and bleeding face. It was a few months after his father's death that he had another quarrel with a friend, and the first fit came on, in which he was very violent. He says he first felt a great weakness come over him, and he recollected nothing more. A few years later another quarrel ensued, when an exactly similar attack occurred. His health was now quite good, but he always felt irritated against his superiors when found any fault with, but never reacted with any show of emotion. He enlisted in the army and became a bandsman attached to one of the regiments. He got on very well until he felt himself not treated justly by his bandmaster, and on matters coming to a head he had three unconscious attacks, in each of which he showed great violence and for which he was sent home to England.

The patient was well educated and readily gave me the above history on inquiry. He was markedly egotistical in his outlook on life, and evinced a narrow and superficial religiousness. There was evidence of tremendous maternal fixation, and it is important to note that there had hardly ever been any sexual desire, and no sexual intercourse had ever taken place, though onanistic practices had occurred at times. We see plainly shown here psychosexual and emotional factors of an abnormal type which evidently have intimate relationship with the outbreak of his unconscious epileptoid attacks. The natural phase of paternal resentment because of the strong maternal fixation was roused to a maximal

height by his father's stern and cruel treatment. But this very severity, emanating from one who after all was his father, and therefore a great man to the childish mind, combined with the fact that his strict orthodox religious upbringing could only tend to inculcate a submissive attitude on his part, made repression of any emotional reaction a natural procedure. As time went on the pent-up and repressed longing to " get his own back " must have been much added to, seeing that his mother had to share his burden. Is it any wonder, then, that at the psychological moment of his quarrel, when his father was robbing him of his lawful prey, as it were, his " unconscious " should impel him to give that blow which the next second was seen to be so revolting to his personal consciousness ? The recurrent dream which filled him with so much horror shows how conative the repressed material was, and one does not find it difficult to understand how, when the old associations were lighted up by fresh quarrels, the unconscious should take advantage of some temporary lack of inhibition to release its flood of surcharged emotional resentment. Yet even at these moments the personality was such that the violence could only occur outside the vista of personal consciousness, and hence the unconscious attacks described. Each opponent, and lastly the bandmaster, who was his superior officer, doubtless were surrogates of the father image. His threat against the life of his first opponent shows how inadequately he still views the past, and how abnormally he will probably react given certain situations. His attacks will certainly recur when he has to face special necessities for adaptation, but it seems a case that modern psychotherapy should be able to do much for.

I must finally add that no epileptiform convulsions in any case were traced to any organic disease of the nervous system, but, as previously stated, some had a history of trauma. One or two were certainly of alcoholic origin. It is not surprising to know that a large number had manifested behaviour of such a type that minor offences had been constantly in evidence. One private who had been a victim of epilepsy since the age of five years, and markedly showed the mental characteristics of chronic epilepsy, finished up a long list of delinquencies by receiving a sentence of ten years' imprisonment for desertion !

CHAPTER XIV

PSYCHOSES WITH ORGANIC BRAIN DISEASE AND ACUTE INFECTIVE DISEASE

THE mental complications of organic cerebral disease have no special relationship with the conditions of active service, differ in no way from such conditions met with in civilian practice, and therefore require no discussion within these pages. Twenty-two cases of this type presented themselves out of the 3,000 admissions, or 0·7 per cent. Two were cases of cerebral tumour, two had meningitis, probably of tuberculous origin, a few were due to arterio-sclerosis, and the rest resulted from the destruction of brain tissue through head wounds. All but the last group demonstrated the importance of a thorough neurological examination. Unless this be undertaken, mistakes in diagnosis are rendered liable. One of the cases of brain tumour was sent as suffering from "early dementia," was later thought to be pure epilepsy, and only on further examination was found to have a cerebral tumour, from which he died soon after. He had been a heavy drinker both in civil life and in the army, so that it was superficially supposed that his mental obfuscation was due to this cause. The arterio-sclerotic cases were necessarily few, as the enlisted men were seldom at that age in which this condition would appear. For the Labour Corps some older men, however, were allowed to join up, and one patient, my oldest, was sixty-five years of age!

The mental cases arising from infective causes were largely composed of those who had been under surgical treatment for more or less severe wounds which became septic. There were twenty-four cases altogether. Though by no means always traceable, it is right to presume that there is always in such a predisposing mental instability. The organic delirium symptoms were usually shown first in a weakness of the

train of thought, loose association, a defective combination of the data of environment, with retention and attention disturbances. Sense impressions became poorly combined, some were not perceived, and others falsified. This led to different variations in the clouding of consciousness, more or less incoherence in speech, memory defects, with often fleeting delusions and hallucinations. Were it not for the patent evidence of the infection, the differentiation from forms of amentia would become extremely difficult. It is not, however needful to discuss this point here. All the cases made a complete recovery. The following case is more or less typical of them all:

Case 29.—Gunner G. P., *æt.* 22 years, was admitted to "D" Block with the following history from France: Nearly three months previous to admission he had sustained a gunshot wound, with a compound fracture of his tibia and humerus, with multiple smaller wounds. He received much surgical treatment, and was in a very collapsed condition. The wounds discharged freely after much pus was let out, but hyperpyrexia nevertheless set in. The patient soon became restless and delirious. At times he was quiet and almost rational, but showed no interest in his environment; at others he was restless, violent, and fought and tried to bite. He tore off his dressings and splints, and attempted to get out of bed. His language was foul, and the content of his conversation usually incoherent. Quite confused and disorientated in time and place. Memory very defective.

On Examination.—In civil life he was a gardener, and though he says he thinks he had a weak heart, he had always had fairly good health prior to enlistment. No history of any nervous trouble, syphilis, or alcohol. Nothing traceable in the family history. He enlisted in March, 1915, and was sent to France in July, 1916, where he was a good deal under fire. He states he could not stand being under fire, which made him very nervous. Says he was in a dugout which was hit by a shell, but can give very little account of subsequent happenings. He is very confused, and his answers are frequently irrelevant. At times he does not seem to comprehend what is said to him. He has no idea when he was wounded, what hospitals he has been in, or how long he has been here. Says he is on the

ship, and wants to get up and walk. He is childish, complains of nothing, and appears to be moderately happy. His memory for remote events is fairly good, but very bad for recent ones. The wounds are nearly healed, and there is no sepsis or pyrexia. Has improved generally in his physical condition. Has been quiet and given no trouble since admission. His improvement continued slowly and surely, so that he was finally discharged from the Service quite recovered mentally.

CHAPTER XV

PSYCHONEUROTIC DISORDERS

Embraced under this heading are 73 cases only, 46 belonging to the category of anxiety hysteria, 22 showed the symptoms of amnesia and amnesic fugue, while 5 were cases of acute hallucinatory delirium. Hardly any of these really should have been sent to " D " Block, Netley. The former patently do not require the treatment and observation of an asylum, and the last named is usually only a very temporary condition which can be treated just as well elsewhere. Nearly all of these patients were at once after examination transferred to the neurological wards.

In anxiety hysteria the most prominent symptoms are mental—a feeling of anxiety and dread without definite cause, sleeplessness, often with terrifying dreams, headache, great exhaustion after trivial mental or physical effort, constituting the most prevalent type, while special phobias may complicate the picture. The psychopathology of this disease is of great interest, and much literature has already been devoted to the subject. It is true, as most authors observe, that a neuropathic tendency is commonly traced in the patients, but we should bear in mind that the development of a neurosis depends upon three factors—heredity, early individual experiences, and the precipitating situation—and if one of these factors be specially predominant the others need be of less account in causation. Now, amid the horrors of modern warfare the precipitating situation is so fundamental and provocative that heredity and past nervous traces need be less necessary as adjuvant ætiological forces. This is where the psychoneuroses of war differ in origin from those of civil life. Mental conflict is undoubtedly at the root of both, but whereas in civil life the conflict is apt to centre around matters pertaining to the sexual instinct, in warfare they find

their root in the instinct of self-preservation. That this was so is confirmed by the fact that the neuroses ceased almost at once being in evidence after the armistice came about, while the psychoses by no means did so. Ernest Jones,* the most eminent British authority on neuroses, states that whether the Freudian view of the origin of the neuroses applies equally to the war neuroses is *sub judice*, though there is every reason to believe that the psychological mechanisms involved have been to some extent modified by the special circumstances and environment of war. However, there is no doubt that in the majority of severe anxiety states there is evidence of a psychopathic instability. One may dismiss without further comment the theories so much promulgated in the early part of the war that these neuroses had their origin in the concussion effects of high explosives and poisoning by noxious gases. The term thus used—shell shock—was found to be misleading, in that the shock of the explosion was only the final precipitant of something already at work, and the same clinical picture was often produced by emotional factors only. Most authors† on the subject have been highly disappointing in discussing the causative factors of anxiety hysteria, and speak only vaguely of fear and emotional shock. The French have added little to our knowledge of psychopathology, although excellent and careful clinical studies have been made.

By far the most illuminating writing on the subject of the war neuroses is given us by MacCurdy,‡ who traces the various symptoms *ab initio*, and points out the various mental conflicts that take place in the patient, and the mechanisms involved in the production of the final clinical picture. It seems to be doubtful if he is correct in assuming that man's aggressive instincts are "sublimated" in active warfare, and that the commencement of the neurosis is due to the failure of this sublimation, whereby he becomes more individualistic, and so feelings of personal harm become paramount. If by sublimation we infer the drafting off of instinctive energy into

* Ernest Jones, "War Shock and Freud's Theory of the Neuroses" (read before the Royal Society of Medicine, Section of Psychiatry, April 9, 1918, published in the Proceedings, vol. xi.).

† See article by author, "A Survey of War Neuropsychiatry," *Mental Hygiene*, vol. ii., No. 3, July, 1918.

‡ J. T. MacCurdy, "War Neuroses," *Psychiatric Bulletin*, July, 1917.

higher channels, such as takes place in modern civilization in the form of competition in sport, business, and position in life generally, it is a moot point whether or no the combative spirit, and even love of the destruction of the enemy, is not a loss of that sublimation from the lowering of inhibition, which aggression is now sanctioned by society and promoted by herd instinct. From this point of view the onset of the neurosis would mean a tendency to a return of the sublimation, with a correlated weakening of the herd influence. Much depends on our exact meaning of the word "sublimation." MacCurdy, in the article already alluded to, discusses excellently the gradual development of symptoms through fear, repression, and mental conflict, until some accidental trauma lights up the fully fledged anxiety state. Though he shows that the physical and emotional trauma of high explosives is only the last straw which suddenly sets aflame and brings to a head a neurotic state which has been more or less slowly incubating for some time, I see no reason why at times such a trauma should not of itself produce neuropathic symptoms in those who had much dynamic repressed material prior to war experience. One effect of the trauma will be to bring about a certain amount of loss of inhibition, whereby failure of repression may easily come about. Any factor causing loss of conscious control may temporarily bring previously repressed complexes to the surface in some distorted way in a psychopathic constitution, and I have certainly met with such causes among those psychoneuroses where no mental conflicts of any moment could be traced immediately prior to the shock.

Stanley Hall,* in his genetic study of fear, points out that the effects of shock are always more or less reversionary, that they strike the weak points, and may erupt at any phyletic level. Thus shock and probably fear reactions and the diathesis of vulnerability to them vary much with individuals, and in general, to understand them, we must not only know the personal history of the subject, but something of the laws of heredity and the history of the race. This idea of shock bringing out prehistoric and sometimes even embryonic

* G. Stanley Hall, "Synthetic Genetic Study of Fear," *American Journal of Psychology*, April and July, 1914.

activities is one which is not sufficiently borne in mind in considering some of the mental reactions met with under war conditions. The phylogenetic aspect should be considered much more than it is, and I am inclined to believe that some of the stuporous states met with have a likely kinship to the cataplexy seen in animal life. It is doubtless often an endeavour to negate reality, but also may involve a self-preservative negation of movement. At any rate, such ideas are suggestive. It should not be lost sight of, nevertheless, that in perpetuating the signs and symptoms of fear reactions the internal secretions may secondarily play a part. Cannon's work on the relation of the emotions to the endocrine organs is highly stimulating. It must be understood, though, that war neurotic states have an intimate relationship with the conditions under which this great war was fought: the enormously high explosives, special trench warfare, poison gases, and horrors that were not present to any extent in previous wars. It is stated that no war neuroses were observed in the Boer War, where the methods were so different, but some traces were seen in the Russo-Japanese War.

What was said in a previous chapter concerning the factor of exhaustion in the production of the psychoses certainly holds good for the neuroses. War experience has not established its importance ætiologically, though it is contributory and will materially aid the psychic elements at work. In the same way we may rule out such a nosological term as "traumatic neurosis."

It has freely been commented on that nearly all psychoneurotic disturbances in soldiers are found only in the unwounded. This is explained by our realizing that the war neurosis is in large part, if not totally, a defence mechanism, an unconscious protest against the distressing situation which results successfully in removal from the environment. The "Tommy" hopes for a "Blighty" wound, but the officer, with his higher ideals, thinks more of death as a release, and as MacCurdy well puts it: "The general antagonism to the situation remains conscious, while some specific wish for relief begins to operate unconsciously and reaches expression when a situation develops that facilitates its transformation into a symptom." The man then tends to seize the opportunity

of some trauma unconsciously, with a conversion hysteria resulting, and the officer renders himself liable to the anxiety neurosis. In either case a wound would probably have solved their difficulty, brought about removal from the line, so that a defence neurosis is uncalled for. This point is confirmed by the almost universal observation that psychoneuroses are extremely rare among prisoners, since the motive, though unconscious, was lacking. Rivers,* wishing to avoid any Freudian interpretation of the term " anxiety neurosis," suggests that since this neurosis is so often accompanied by repression, and so many of its symptoms can be ascribed to this ætiological factor, " repression neurosis " might seem to afford an alternative term. Though it is true that repression is the great factor in anxiety states, it is also and equally so in all psychoneuroses, so that such a term as Rivers proposes would be scientifically misleading.

It surprised me to see that Eager, of the Lord Derby War Hospital, placed 6 per cent. of his French Expeditionary Force under the heading of "Neurasthenia." Unfortunately, this term for years has meant little, but in the army nomenclature it has absolutely lost any scientific value it ever had, since any functional syndrome seems thus officially designated. Any nerve disorder short of insanity that is not patently hysterical is thus connoted. Modern psychopathologists have marked out a very definite syndrome as designative of this disease, and when other morbid symptoms present themselves, it only leads to nosological and scientific confusion to bring this term into use. Sir John Collie,† in a recent article, writes on this disorder as though it were the prevalent nervous disorder met with in the war, and makes such statements as the following: " Most, if not all, of the cases of neurasthenia arising in the army are the result of actual concussions (shell shock) or the conditions prevailing in modern warfare." " It is obvious that the origin of the *conglomerate collection of symptoms*‡ which go to make up the content of neurasthenia is mental." Greater scientific accuracy than this is required

* W. H. R. Rivers, " War Neurosis and Military Training," *Mental Hygiene*, vol. ii., No. 4, October, 1918.

† Sir John Collie, " Management of War Neuroses and Allied Disorders in the Army," *Mental Hygiene*, vol. ii., January, 1918.

‡ The italics are mine.

after the forty years since it was described by Van Deusen. Ernest Jones* says: "The term should be restricted to its primary meaning of a fatigue neurosis, the cardinal symptoms of which are an inordinate sense of mental and physical fatigue, difficulty in concentration, in attention, and application to work, sense of pressure on the head, spinal irritation, flatulent dyspepsia and constipation." He states, too, that he has not come across a single case in connection with the war, and though I have had considerable experience in neurological wards I met with very few that could rightly be brought under such a heading. The example of neurasthenia that Eager brings forward in illustration is evidently a psychoneurosis.

Amnesic fugues were constantly seen in the front line, and in all probability more than one such sufferer has been shot for desertion. Courts-martial on such cases were frequent, and in most cases they were officially regarded as temporarily insane, not responsible, and sent home. The patient may, or may not, have been the victim of some physical or psychical shock. He wanders away a variable distance, and when he comes to himself, gives himself up, or is apprehended, he has a complete amnesia for the period of the fugue. On regaining his personal consciousness he commonly complains of headache, nothing more, though some slight mental obfuscation may exist for a few days. Quick recovery is the rule, and by the time the soldier reaches England there are usually no abnormal objective signs and no untoward symptoms except the special amnesia, which memory gap can usually be easily recovered by simple psychotherapeutic measures such as simple association in a passive or hypnoid state or by hypnotic suggestion.

Amnesias of various types without any fugues were also encountered, though both of such types of cases were usually and rightly sent to neurological hospitals. The amnesia may involve some limited period of time. It may involve the memory since enlistment, or it may be so retrograde as to involve the whole of life's experiences with certain limitations, so that the patient knows nothing of his previous history, not even his name. It is upon such a foundation as this that secondary personalities are formed. Some of these cases are

* Ernest Jones, "Psycho-Analysis," Baillière, Tindall and Cox.

difficult to cure, but the majority yield to proper treatment with patience.

The question of the genuineness of the fugues has been often doubted, and more especially by those who, having no knowledge of or interest in psychological medicine, are always ready to see evidence of malingering in such conditions. Nevertheless, all important observers regard these fugues as a very definite pathological state akin to somnambulism. The wanderings, of course, are not purposeless, any more than sleep-walking is, and there is good reason for believing that a desire to leave the particular environment involved which has been probably conscious at one time, or partially so, and then repressed into the unconscious, is the basic factor. Superficial psychological investigation of such cases supports such a theory. It is, therefore, unconscious desertion. Consciously, desertion would not be entertained seriously as a mode of reaction to the conflicts that beset them, but in psychopathic individuals, when factors produce some loss of conscious inhibition, the unconscious takes control and the fugue results. Many showed similar tendencies in civil life. The soldier with a normal mental condition is not likely to show this symptom.

In the above I have not intended to refer to those special cases where amnesia has resulted from trauma, epilepsy, or alcohol, or where the fugue was only a symptom of a definite psychotic state, such as general paresis or dementia præcox. Any reader interested in the question might well peruse some clinical studies on the subject by D. K. Henderson.* The following case illustrates the type of amnesic fugue I have referred to:

Case 30.—Private G. H., *æt.* 26 years, was admitted from France with the statement that he had been released from arrest without prejudice, as he had been found to be liable to hysterical amnesia, when he behaved automatically.

On Examination.—In civil life he was always nervous, and about five years ago he had a nervous breakdown. He became fearful, had bad nightmares, and became depressed and sleepless. He could assign no cause for this. He has never

* D. K. Henderson, "War Psychoses: Amnesia as a Defence Mechanism," *Review of Neurology and Psychiatry*, May to June, 1918.

had any sexual experience or conscious desire for such. Up to two years ago he used to wet his bed most nights. No neuropathic or psychopathic family history. He enlisted in September, 1914, liked the army, got on fairly well training, but became only a second-class shot. In December, 1915, he went to Egypt, where he saw no fighting. He was transferred to France in March, 1916, where he had plenty of trench experience, but was not wounded. The shell fire upset him a good deal, and he became nervous and sleepless, so that at times he avers he did not know what he was doing. Because of this he was taken off routine work and made an officer's servant. In June of that year he was in hospital for seven days, as he became unconscious from a shell bursting some distance off. He came to himself with a bad headache, but, soon improving, he was returned to duty. A few days later he wandered away some miles after a bombardment. He was sent to the Base, where he had another wandering attack, and on returning to the line the fugues continued. He was then seen by Lieut.-Colonel Myers, the Consulting Mental Specialist, who had him transferred to a mental ward at the Base. He was there for four months, and says he kept fairly well except when he heard any anti-aircraft guns go off, when he became excitable and nervous for a time. It seems that all this time he was under arrest, and was finally sent back for a court-martial, but, having more attacks, he was again placed under observation until transfer to Netley. He now states that he is quite all right, and complains of nothing. He answers readily and rationally, gives a good account of himself, and evinces a good memory except for the special wandering periods. His affect is normal, and he shows no abnormal neurological signs except that his tendon reflexes are somewhat exaggerated. He was transferred to the neurological wards.

The next case illustrates a severe form of amnesia which is by no means commonly met with in civil life.

Case 31.—Private H. E., *æt.* 27 years, was admitted from France labelled "Amnesia," and with the history that "he was quite unable to give any information about his previous life. He was somewhat dull, listless, depressed, and asocial, though he feels it that others do not ask him to join in their games. He did not know how to write a letter or how to open an

umbrella. Had no idea who he was, where he came from, or anything about his past life until he got to the Field Ambulance."

On Examination.—He can give little account of himself, though his past memory is somewhat selective. He tells me his native town, and says he thinks he is married, with a child, but he recollects nothing of his past life, except that now and again he gets isolated images of his wife and sees himself running about as a little boy. Is not sure that he would recognize his wife if he saw her. The last thing he recollects is being in hospital, and since then his memory retention has been fair, but now and again he forgets unimportant details. He can read pretty well, but cannot write a letter properly. He understands all that is said to him, and recognizes the names and use of all common articles except a few. Cannot name half a crown, for instance, and even over simple arithmetical calculation he is very slow. He looks dejected and nervous, and tears come easily to his eyes. He is fully orientated and is not unhappy, but says he feels strange here. Eats and sleeps well, and there is no evidence of any psychosis. Physical state good. No tremor, but tendon reflexes are somewhat exaggerated, and he shows an excessive reaction to all strong sensory stimuli. He also was at once transferred to neurological wards for treatment.

The reasons for such acute mental dissociation causing such a profound amnesia are always interesting to unravel, though in war-time there is little opportunity for such a prolonged analysis. On active service the basic root probably always lies in the repression of what is repugnant to the personality in the environment, and in which certain experiences have a large share. In an individual predisposed to psychopathic dissociation the cleavage may extend deeply, as it did in the last case, where there was no history of any organic trauma.

Another result of acute mental dissociation is seen in the *acute hallucinatory delirium*, of which five cases were sent to Netley. The majority of such cases, though not very common, were rightly cared for in neurological centres. In the earlier part of the war many medical officers did not recognize the condition, and labelled such cases as "Mania" and "Confusional insanity." The French school, following the example

of Régis, mostly adopt the heading "Oneiric delirium" for these patients. The condition is rightly and truly described as a dream lived through. Usually following some specially vivid psychic trauma, all sense of reality is lost, and for a time the soldier relives over and over again particular war experiences. At the front they constitute a great danger to themselves and others; not realizing their position and environment, they may rush hither and thither irrespective of danger. In hospital they are somewhat restless, and so engrossed in their delirious thoughts that they may be quite inaccessible to the outside world. They imagine themselves in line of battle, take up attitudes of defence, holding up a stick given them as a rifle, see bombs dropping from aeroplanes, have visions of the enemy surrounding them, and warn others of the dangers which seem to beset them. Apprehension is patent, and the attention remains fixed on the vivid hallucinations, both visual and auditory. The content of speech is often circumscribed to certain words or phrases. One patient of mine would constantly reiterate "Delville Wood, Delville Wood" (the scene of a fierce fight he had experienced), "There's George" (the name of a chum who was killed beside him), and at times he would implore those around to "take cover." Notwithstanding these symptoms, manifesting continual alertness and excitement, such patients often eat and sleep well. The condition is usually very temporary, and within a few days they suddenly wake up out of sleep, having regained their normal personality, now in touch with reality, and with a complete amnesia for the dissociated period. Analogous psychopathic states are, of course, met with in civil life, though these hysterical deliria are not common. Janet's clinical description and discussion of such cases are well known.

CHAPTER XVI

MALINGERING—SUICIDE

It has, I think, been more or less universally recognized by all those who have a right to voice an opinion that malingering has been a rarity in the late war. At any rate, this has been so as regards nervous and mental disease. Among the millions of men in the army there must, of course, have been a good few who endeavoured to "swing the lead," but I believe that this mainly concerned the more trivial ailments at sick parade, and little was seen of this where more serious illness was involved. Where mental disease was concerned malingering has been, I believe, non-existent, or practically so, except in cases where soldiers have been prisoners of war in the hands of the Germans, and have simulated insanity in order, if possible, to be repatriated. A good many who were admitted to Netley have been successful in this way, and openly confessed to their action. They gave me in detail the procedures they had adopted to thus deceive the German authorities, and told their story with evident amusement and pride. It seems that the symptoms they found most easy of performance were those of seeming depression with some confusion. They would depict a haggard look, hardly reply to questions, and mumble to themselves. Most of them were too knowing to adopt delusional or hallucinatory symptoms, which they probably would not have been able to live up to for long. Presumably the observation of such cases was limited, and ignorance of the English tongue helped the simulator. One prisoner of war, having been brutally treated, rebelled and showed intense violence and resentment, so that he was put into a guard-room. When an officer visited on an inspection round and inquired of the guard what had been the matter he was told that the prisoner was mad. This put the idea into the soldier's head; he feigned insanity, and with complete success. Except in these prisoners of war, I met with no instance of malingering, though one or two were for a time

under suspicion. A greater danger, perhaps, lies in the simulation of recovery, and in the pretence that the ailment was only slight and temporary.

At the commencement of the war all mental troubles were much under suspicion, and medical officers untrained in such matters generally looked with no kindly eye upon the neurotic sufferer. It is quite a common fallacy on the part of the medical profession to think that simulation of insanity is fairly frequent. The difficulties of keeping up any acting part precludes most from the attempt, and the fear of discovery and subsequent punishment is probably also a deterrent to the soldier. He knows, too, how much his comrades despise such an attitude.

The malingerer has been studied more deeply of late years by psychopathologists, and the view has gained ground that simulation itself indicates a mental abnormality, and as our psychiatric knowledge grows we find that the reported cases become much less in number. Kraepelin stated: "I have grown more and more conservative as to pure simulation, and I have seen a large number of my former simulators become demented"; and "The most experienced psychiatrists admit that the number of entirely well men found among simulators is constantly decreasing." Sandy* points out that it is certainly an abnormal way of meeting a difficulty, and that malingering itself is simply often, if not always, a defence reaction, and as such is allied to the psychoses representing merely the effort of the individual to escape difficulty, an inadequate reaction to environment. Glueck† has discussed the question in a very interesting paper, where he compares the malingerer to the ordinary and pathological liar. One of my admissions was an exceedingly interesting case of pseudologia phantastica which I have published‡ in detail elsewhere. He accused himself of being a spy in the pay of the Germans, and wove fantastic details of his machinations, and to such an extent that for a long time he was believed and was in danger of execution. Even this anticipated sentence

* William C. Sandy, "Malingering: A Problematical Case," *American Journal of Insanity*, January, 1918.

† Bernard Glueck, "The Malingerer: A Clinical Study." International Clinics, 1915, vol. iii., series 25.

‡ Review of "Neurology and Psychiatry," vol. xvi., Nos. 7, 8, July-August, 1918.

of death did not deter him from continuing his lying course, and so great was his craving for the dramatic and desire for notoriety that he told me he pictured himself with elation standing before the firing squad, tearing the bandage from his eyes, and in an heroic attitude declaiming that he was not afraid to die for the cause. It is instructive to see how far a pathological liar will go in the glorification of his ego.

The only case admitted to Netley with a definite history of some simulation was the following one, where " fits " were put on:

Case 32.—Rifleman F. T., *æt.* 19 years, was admitted from India with the history that he had had many fits, and subsequently had talked incoherently to himself, smiled vacantly, and passed urine in his bed. Said to have been dull and apathetic, and once attempted to wound himself with a knife. He was carried on board ship as an epileptic, frothing at the mouth, but was found later to be feigning epilepsy. He admitted it, and said he had done the same on former occasions. Said also to talk childishly.

On Examination.—He was a labourer in civil life, and no neuropathic history is traced in him or his family. States he enlisted in January, 1915, and went to India in February, 1916. He says that all the men in his regiment were old, and they used to say that he ought to be in the trenches. States that he malingered to get to France, and that the fits were all put on, even those he had on board. He does not seem able to understand that these fits could not help him to get to France, as he was coming home in any case. Last night he wet his bed, but said it was only an accident, and he had never done it before. He shows no psychotic symptoms, but is simple-minded and childish. No abnormal neurological signs are found. He was diagnosed later as a case of mental deficiency, but absconded from the War Hospital to which he was transferred, and not traced.

Suicide.

There are certain points of interest to comment on with regard to suicide as met with under active service conditions. Among my 3,000 Expeditionary cases 105 had attempted suicide, and 3 were successful in thus ending their lives in the War Mental Hospitals to which they were transferred. For some reason suicides are generally twice as frequent in

military life as in civilian, and in the British Army in 1909 the rate per 1,000 men was 0·30. First, as to the means employed. It is usually stated that different individuals tend to choose the means of suicide to some extent according to their occupation. Certainly there are excellent grounds for presuming that definite psychic factors aid in the choice, and that mental analysis would often reveal the reason why drowning, poisoning, etc., specially appealed to the individual as a means of taking his own life. It is, therefore, an interesting point that the vast majority of British soldiers in the late war used the razor for this purpose, and cut their throats instead of using the rifle, which one would superficially suppose to be the handiest weapon. I do not think, either, that the mechanical difficulties in using the firearm is sufficient to explain why it was so seldom chosen. Richards* states that gunshot wounds form the favourite method for soldiers to commit suicide, and that in the American Army they found among the methods of suicides gunshot wounds to be 38·4 per cent. in 1907 and 55 per cent. in 1910. The majority of suicides that occurred in my cases were among those who were in the depressed phase of manic-depressive insanity, and many also among the acutely hallucinated paranoiacs who, driven to desperation through the continuous accusing voices, sought seemingly an end to their existence. A few occurred in quite temporary confusional states, where one could trace no previous mental depression or evidence of mental conflict. The act was sometimes premeditated and sometimes not, and amnesia for the act itself was extremely frequent. Such memory gaps are common enough when certain antisocial acts are performed, and they become necessarily of great medico-legal interest. Though the genuineness of such amnesias is often called in question, there is no doubt that they do often truly exist, and doubtless the memory could be recovered by special means. Through the conscious personality repression and dissociation take place as a result of the mental conflict, and the suicidal act is performed while in this dissociated state. The same pathological basis exists as in the amnesic fugue.

Suicide mainly involves the negation of reality. It is the farthermost limit of that flight from reality which in some

* R. L. Richards, "Nervous and Mental Disorders in their Military Relations," White and Jelliffe's "Nervous and Mental Diseases," vol. i.

degree or other tends perhaps to be the most fundamental human trend. The psychology of suicide requires more studying. It is much too often taken at its surface value. We have already seen in the discussion on the idea of death how its conception from the point of view of annihilation cannot be grasped by the human mind consciously or unconsciously, and there are reasons for believing that the individual who does succeed in ending his life has unconsciously gone farther than he intended. The increasing number of suicides among school children render it patent that there is some deeper psychological substratum in relation to the act than the mere ending of life. In children it is even occasionally seen as early as six or seven years, and Eulenberg,* in his table showing the causes of 1,117 child suicides in Prussia, gives 336 as due only to fear of punishment, and 52 to fear of failure in examination.

Wholey† has made some interesting observations on this subject in discussing a case of an alcoholic toxic psychosis of his. He says: "The regularity with which we find the alcoholic attempting suicide by throat laceration lends confirmation to the theory that 'birth fantasy' determines the manner of suicide. Such an interpretation of the psychology of the alcoholic is in keeping with the theory of his homosexual fixation. . . . It is to be noted that it is not the affect-depression of the melancholic which drives these patients to suicide, but an overwhelming urge to escape from an imminent death attended by the most hideous torture and mutilation. . . . The alcoholic's torture practically always includes mutilation of the genital organs." There is great reason to believe that in many, if not all suicides, factors in the unconscious mind are mainly responsible, but I regret I cannot follow Wholey's meaning when he connects throat laceration with the idea of "birth fantasy," which I find is also spoken of by no less a psychiatric authority than William White of Washington. At any rate, these ideas are suggestive, and one welcomes them as an advance in our conception of the pathology of suicide. I hope at some future date to be able to throw more psychological light on the subject.

* Albert Eulenberg, "Schülerselbstmorde," *Zeit. f. Ped. Psych.*, 1907.

† C. C. Wholey, "Revelations of the Unconscious in a Toxic (Alcoholic) Psychosis," *American Journal of Insanity*, January, 1918.

CHAPTER XVII

CONCLUSION

We have seen, then, from the foregoing pages that the circumstances and horrors of modern warfare produce no new forms of psychosis, but only tend to modify the prevalence of certain types of mental reaction. I do not suppose for a moment that any modern psychiatrist would have prognosticated otherwise before the commencement of hostilities, for all our advance in knowledge points to a greater unifying of the biological psychoses, though we draw certain clinical distinctions of avowedly an artificial nature, and so create various disease entities. The more or less special age-limit of the combatant soldier precludes us seeing much of those forms of mental disorders which tend to show themselves after forty years of age, such as general paresis, the presenile and the senile psychopathies. My analytic results show that, compared with the morbid mental reactions met with in civil life, we see more of the confusional and paranoid forms, and the suggested reasons for this have been already discussed in a previous chapter. One must not forget, though, in relation to the whole of one's findings, that during the war, types of cases were sent to War Mental Hospitals that would not for a moment have been admitted to asylums in peace-time, partly because of their mild and temporary nature. Medical officers in the various theatres of war overseas also transferred certain cases to Netley which were, strictly speaking, not psychotic or suitable for admission, sometimes through mistaken diagnosis, and at others because they had to be officially regarded as insane in order to render them not responsible for acts otherwise punishable. All this renders any comparison of my statistics with civil figures practically valueless. The recovery rate was fairly high—45·8 per cent.—and if from the total cases the pure mental defects were eliminated, the

rate would become 52·6 per cent., and probably still higher, if the results of the cases which were repatriated could be traced. Though I venture on no comparisons, there is good reason for believing that the early detection of morbid symptoms, rapid removal from the environment, and undelayed supervision and treatment, must have had a material effect in aborting many disorders and adding greatly to their chances of recovery. Though the War Office kindly supplied me confidentially with the average number of troops engaged in Expeditionary work during 1917, the population was such a changing one that any percentage deductions with regard to mental disease would be useless. The Board of Control admission returns for 1917 do not show any age classification, which again renders any comparison between war and civil insane perfectly valueless. No attempt, therefore, will be made in this direction.

Mention has already been made more than once about the recruiting of the mentally unfit, and though at certain periods of the war it was doubtless absolutely necessary to get every available man within the ranks, that more discrimination in this direction should have been made somehow, no impartial observer I think would deny. It was not feasible for a mental expert to be a member of every recruiting board, but the patently doubtful cases—and there must have been very large numbers of these—could and should have been referred to a mental specialist's decision. Many were so evidently psychopathic and defective that there seems little excuse for their enrolment. Still less was there for enlisting such men after the armistice, and yet during the past few months a few were admitted to Netley who were grossly mentally defective, and who joined up very recently. It is to some extent a debatable point as to whether a man should be enlisted who has a history of a previous psychosis. A general answer I do not think scientifically can be given, though perhaps an ideal army would have none such in its ranks. Each case should be dealt with on its individual merits, though if an individual has certain latent psychopathic tendencies they are likely to be brought to light by the stress and exigencies of war circumstances. At the time of enlistment it is very difficult to scientifically sum up the amount of mental defect that may

exist. Standardized tests should be used, and would be extremely useful in gauging fitness for service. America, not accustomed to do things by halves, commissioned 260 psychiatrists and neurologists, who were on duty in the various camps weeding out recruits who were unfit for military duty because of neuropathic or psychopathic conditions, and the Surgeon-General drew up a general outline to be followed in determining the recruits to be excluded because of such disease.

For some time after the outbreak of war the only organization for mental service patients was that according to peace-time regulations, until the numbers admitted aroused the authorities to action, and slowly but surely the arrangements were formulated which I have detailed in a former chapter. The limited accommodation at "D" Block, Netley, was soon at too high pressure, and without scientific or expert examination the men had to be rapidly evacuated to civil asylums.

This now brings us to the absorbing theme of what the late war has taught the military authorities, the medical profession, and society as a whole. What about the future of military psychiatry? What about mental medicine as it exists to-day? What changes are necessary? It were easy to dilate at great length on any of these problems, for the need of change is great.

It is certain that as psychiatric medicine is having its importance more recognized in civilian life, the military authorities will have to develop this branch in the Royal Army Medical Corps, and by its scientific application do much to improve the mental status of the soldier. The sooner some officers become *thoroughly* trained in this speciality the better. The late war has given an enormous impetus to the necessity for active interest in psychopathic disorders, and the lessons learnt should immediately instigate a line of organization by means of which the soldier's mentality can be judged accurately, so that his fitness for any particular form of service may be gauged. This would not only mean increased efficiency through elimination of the unfit, but increased efficiency by seeing that the soldier is psychologically suited for his particular work. Thorough psychiatric knowledge, too, would bring an added justice in its train, as the delinquent is then seen in the right perspective. All frequent offenders, and certainly a large proportion of court-martial cases, should

be mentally examined in order to get at the basic root of their antisocial acts, and so treat the offender and not the offence. This certainly has been a lack in the Service organization during the war, when organic neurologists with no psychiatric training have been called on to determine the question of responsibility of such men.

It is said that the French have to some extent classified those newly joined according to mental and physical characteristics in four groups—the gastro-intestinal, the muscular, the nervous, and the respiratory—and on the basis of this they have placed the men on military duty. Thus the gastro-intestinal type have the positions involving great physical strain given them; using the muscular type for continuous hard labour; assigning to work which may at any moment make extraordinary demands for reserve energy and quick response the nervous type; and using for aviational service the best of the respiratory type. I confess that this rough-and-ready classification of men does not seem very scientific, but at any rate it can be said that in even thus summing up the type of man for vocational purposes a step is taken in the right direction. Trained psychologists should be able to apply their knowledge in a more fruitful way. Yerkes* has pointed out how psychological principles may aid the military organization, and he draws special attention to this in the study of gunnery and the examination of aviation recruits. He rightly says: "If psychologists—experts in the study of behaviour that they should be—are not able to render signal service to the nation by discovering and indicating in practical ways the relations of human characteristics to special tasks, they certainly will deserve and receive but little consideration from their fellow-men of science." Rivers,† believing that much psychopathic disorder is predisposed to by the form of training which renders the soldier highly suggestible, thinks that much might be done in the way of prevention by modifying those features which tend to bring about this result. He feels that the encouragement of independence and a less mechanical training should lessen the

* Robert M. Yerkes, "The Relation of Psychology to Military Activities," *Mental Hygiene*, vol. i., No. 3, July, 1917.

† W. H. R. Rivers, "War Neurosis and Military Training," *Mental Hygiene*, vol. ii., No. 4, October, 1918.

tendency to heighten suggestibility, and so diminish those warfare attacks of hysteria which he likes to term "suggestion neurosis."

After a man has been recruited his mentality still often requires supervision, and medical officers of regiments should, especially when on active service, be constantly on the look-out for the prodromal symptoms of nervous or mental break-downs. A definite procedure with this aim in view was carried out in the American Army, where a rapid routine examination was made and then a careful examination of all suspects obtained from the first examination. Commanding officers were requested to give a list of all such suspects. Captain Bowman,* of the United States Army, gives some interesting results from such a procedure. In all, 1,189 cases were examined, and in 54·4 per cent. the findings were negative in every way, and 475 cases showed positive findings. Of these 475, 69 showed sufficient evidence of mental deviation to warrant further examination, and 59 of these were classed as mental defectives, and 10 were classed as unstable emotionally. He classifies also the most important abnormal neurological signs that were found. In the second examination 144 were studied, and of these 27 were recommended for discharge. The diagnoses in these cases were: "Defective mental development, 6; defective mental development and epilepsy, 3; defective mental development and constitutional inferiority, 3; defective mental development and constitutional inferiority with psychosis, 3; chorea, 3; exophthalmic goitre, 3; exophthalmic goitre and defective mental development, 1; hyperthyroidism, 1; hyperthyroidism and anxiety neurosis, 1; dementia præcox and drug addict, 1; epilepsy, grand mal, 1; epilepsy, petit mal, 1; constitutional psychopathic state, 1. He generalizes his conclusions thus: "There are at present throughout the army, and more especially among those organizations composed of recruits, a considerable number of cases of nervous and mental diseases. By this examination many of these cases can be detected and discharged, thus freeing the army of men who not only would be of no value, but who would be a burden and detriment to the Service."

* K. M. Bowman, "Report of the Examination of the —— Regiment, U.S. Army, for Nervous and Mental Diseases," *American Journal of Insanity*, April, 1918.

One cannot help but feel that if only some such organization had existed on these lines in the British Army how much more efficacious must the Service have become.

In the discussion on the ætiology of the war psychoses I have laid great stress on their psychogenic origin, and the recognition that mental conflict as a basic factor in so much mental disease has its practical applications. If means were taken that soldiers could more freely vent grievances and feel that sympathy and understanding were given them, if personal worries could be aired and advice sought, and if as little as possible any rankling sense of injustice were allowed to exist by a deeper study of those who come in conflict with disciplinary law, many a mental disorder might be nipped in the bud. It is probable that in time of war the opportunities of carrying out such ideals are few, but even in such circumstances the neurotic and mental patient must be viewed more as a sick man and with a more kindly eye. It must be understood that such cases require as much care and attention and skill as the case of physical illness, and not looked upon with suspicion as partial if not total malingerers.

In speaking of hysteria and the attitude that most medical men take up with regard to it, Freud* very pertinently says: "The doctor acts quite differently towards hystericals than towards patients suffering from organic disease. He will not bring the same interest to the former as to the latter, since their suffering is much less serious, and yet seems to set up the claim to be valued just as seriously. But there is another motive in the action. . . . Before the details of hysterical symptoms, his knowledge, his anatomical, physiological, and pathological education desert him. He cannot understand hysteria. He is in the same position before it as a layman. And that is not agreeable to anyone who is in the habit of setting such a high valuation upon his knowledge. Hystericals, accordingly, tend to lose his sympathy; he considers them persons who overstep the laws of his science, as the orthodox regard hereties; he ascribes to them all possible evil, blames them for exaggeration and intentional deceit, simulation, and he punishes them by withdrawing his

* Sigmund Freud, "Origin and Development of Psycho-Analysis," Five Lectures at Clark University, September, 1909, *American Journal of Psychology*, April, 1910.

interest." This is unfortunately true enough, and Freud's remarks largely hold good for most mental disorders. Such an outlook can only be gradually eradicated by education, and this applies to civil as well as military psychiatry. Since the armistice was declared large numbers of psychotic sufferers continued to be admitted (see chart opposite p. 50) when the stress and strain of warfare had ended. Mental conflicts concerning demobilization were frequent, besides other personal ones which are always liable to be set up. The process of civilization seems to breed conflict, so that freedom from worry is a mirage, but much may be done to obviate to some extent, and more to modify and assuage.

The Present-Day Position of British Psychiatry

Much that we have learnt through the late war brings home to us in a vivid way defects that exist in our medical organization, and among the most glaring of these, perhaps, is the position of mental medicine. It seems rather that British psychiatry has not tended to keep as much abreast of modern psychological knowledge or research as it might have done, but has shown an inhibiting conservatism which has not redounded to its credit or progress. The medical educative curriculum sadly lacks adequate instruction in psychology, normal or morbid, without which an asylum medical officer can hardly do justice either to himself or to his patients. No special training has been required from the recruits to mental hospitals, and no encouragement is subsequently given to any post-graduate work, with the result that an asylum post has been looked upon as one where the social side was of more importance than the scientific, where work need not be arduous, and where by dint of time alone the giddy height of a superintendentship might appear upon the horizon. The hospital curriculum should aim at giving even those who will be general practitioners some slight insight into the workings of the human mind, for there are few patients with whom they have to deal that do not present some problem, large or small, with which they should be able to cope. Some such knowledge should teach the practitioner sufficient, so that he recognizes that the many patients he has been accustomed to tell there is nothing the matter with them, because they

have so-called "functional" symptoms, are really ill. He will then understand that there is a great deal of difference between an imaginary disease and a disease of the imagination. The paradox that "if a man is ill enough to think he is ill when he is not ill, he must be very ill indeed," will become clearer to him. The nervous ailments, instead of being a bore, will be full of interest, and the patient will benefit accordingly. One realizes, of course, that it is impossible to extend a medical curriculum indefinitely, and that a medical man cannot know everything; but surely it is baldly an absurdity that a fully qualified doctor should be absolutely ignorant of some of the simple principles of mental functioning in its normal and abnormal aspects. He already learns much of departments of medicine which as a general practitioner he will probably never apply, but such knowledge is helpful and necessary for a correct summing up of cases that he will be called upon to deal with. With regard to the mental factor it is different, for he not only has to face clinical phenomena in this sphere, but should be able scientifically to apply some simple form of psychotherapy. A quite superficial tuition would enhance his value as a healer a thousandfold. I have found that most medical practitioners are cognizant of this want.

Notwithstanding this lack of knowledge of diseases of the mind, any medical man has the legal right to certify and commit an individual to an asylum. If the patient be acutely insane, with manifest delusions and hallucinations, the medical opinion is only confirmation of the obvious; and if, as is so often the case, the patient is not so obviously insane, and does not present a glaring irrationality, he may refuse to certify, so that a dangerous paranoiac or a commencing dementia præcox goes unrecognized, to the danger of the public and the individuals themselves. His few visits to an asylum when a student, and which are then looked upon usually as amusement, are, of course, more or less useless. Reform is direly needed here. There should be a local mental expert for the purpose of all certification, in the same way that it has been recognized that the average medical practitioner is not a practised pathologist, and not usually competent to trace the causes of death post-mortem, so that special expert pathologists have been employed for this purpose in many districts.

With regard to our asylum medical officers, the Medico-Psychological Association has for some time inquired into their status and advised for the amelioration of their position. That there is little inducement for an ambitious medical officer to enter asylum work is patent. The advertisements for junior posts frankly state that no previous experience is necessary, and he will perhaps learn little subsequently. The financial remuneration has been grossly inadequate; there was no chance of marriage; he was shut off from the outside world and allowed to stagnate. The numbers of medical officers in asylums are too small to render adequate individual treatment possible. No wonder, then, that mental diseases are looked upon as more or less hopeless to treat, that Nature alone has her own way, and that walking round the wards twice daily is all that is considered necessary. It is interesting to note that in the asylum at Tokyo, in Japan, there are ten physicians working in the hospital with a capacity of 500 beds. Shall we ever arrive at such an ideal in England? A medical superintendent as an administrator has little or no time to devote himself to clinical work just when his experience should have made him especially useful to his patients and his junior staff. It is, therefore, not surprising that so few contributions towards the advance of psychiatric knowledge are made in this country by men in such a position.

Among other reforms needed, the necessity for out-patient and in-patient institutions for the advice and treatment of psychopathic disorders which are not psychotic or certifiable stands out prominently. The sufferer from a psychoneurosis is in a poor position indeed, since so few have cared to endeavour to understand him. The average neurologist seems to devote all his energies to organic disease, and the non-organic patient is labelled "Functional," perhaps given bromide, and then left much to his own devices. The neurologist usually has no psychological or psychiatric training, and the psychiatrist usually no neurological or psychological, so that we have three departments of medicine in more or less watertight compartments when they should be something of each. Between the special workers in these three branches the neurotic fails to find relief or understanding. Those who suffer from the prodromal symptoms of a psychosis can also not easily gain any skilled advice. That many psychoses

could be aborted by early advice and treatment goes without saying. The Board of Control, in their Report for 1917, draw attention to this point, and state: "Among rich and poor alike difficulty is experienced in recognizing and treating in their earlier stages indications of mental disorder. The difficulty arises partly from ignorance and partly from reluctance to admit symptoms pointing to mental affection—a reluctance due to the dread of being labelled a mental case, with the possibility of certification and its supposed stigma. Much time is lost or wasted on mere palliative measures, during which the patients struggle to carry on their normal occupations; many become permanent nervous invalids, while others are sent to asylums, but only when it is too late for them to derive full benefit from the remedial measures provided in those institutions, which at an early stage might have been completely successful. This regrettable delay, the Board think, in many instances might have been avoided had inducements and facilities been held out for seeking an early diagnosis of the nature and character of the disease under skilled advice, and had provision been made for its treatment apart from the existing provisions of the Lunacy Law." The Board, therefore, make many excellent suggestions for amendments of the lunacy laws, and encourage the idea of out-patients at general hospitals and special institutions.

In America, through the influence of that most excellent organization the National Committee of Mental Hygiene, such facilities have for some time been put in practice, and with excellent results. It is highly interesting to note that the great work consummated in America of late years through this committee has to be primarily laid at the door of a layman who himself had passed through the experience of a psychosis, and who thereby realized to its fullest extent the then drawbacks of lunacy administration and the lack of prophylactic measures. As he himself says:* "Though my original plan, as presented in 1908 in the first edition of my autobiography, 'A Mind that found Itself,'† was to create a type of social agency that should work exclusively for the insane and for the prevention of mental diseases, I builded better than I

* Clifford W. Beers, "Organized Work in Mental Hygiene," *Mental Hygiene*, vol. i., No. 1, January, 1917.

† A book that every psychiatrist should read.

knew. In striving to help the insane and to conserve mental health, the National Committee soon found itself called upon to help also the mentally defective, the epileptic, the inebriate —in fact, all of the mentally abnormal groups." The work subsequently done in nearly the whole of the United States through the organization of the committee has had far-reaching results of such an excellent nature that one must earnestly hope that some such movement will be started in our own country.* A great feature upon which much of the committee's success has depended is the psychiatric social work.† This has been a very special branch of late in order to supervise scientifically the well-being of those soldiers who have been discharged the Service for nervous and mental disorders. Intelligent and educated lady volunteers were selected and trained theoretically in psychology, sociology, psychiatry, etc., and then practically in their various applications to social work. The results were so excellent and their social value so patent that there has arisen a growing belief that social work is tending in America to become a profession that will eventually demand academic and practical training comparable with the education now required for the established professions. Such work in England is sorely needed, but can only be successful through being part of a larger organization devoted to mental hygiene as a whole.

A " People's League of Health " has just been founded in England for the purpose of attempting to help the individual citizen to knowledge of health matters, but the factors connected with disease in general are so extensive that one feels that mental health, in the wide sense of the term, should be dealt with by a special organization. One sees evidence of psychological principles being more adopted in their application to daily life, and it is rightful to hope that in time they will be used as aids to the solution of such problems as the insane, the criminal, the feeble-minded, the drunkard, the vagrant, and the prostitute, which have been hitherto taken so much at their surface value. We have had certain health crusades in special directions. Some years ago it was against

* Any reader sufficiently interested should obtain copies of the journal *Mental Hygiene*, and therein learn the details of the work done.

† See " The Training of Psychiatric Social Work at Smith College," *Mental Hygiene*, vol. ii., No. 4, October, 1918.

tubercle in all its forms, and we are now in the midst of a campaign to combat venereal disease. Just as important for the welfare and prosperity of the nation is a crusade necessary to root out scientifically the basic factors of mental abnormalities. There has been far too much tendency to regard the psychologist as a crank who, from his study of the mind, is forced to see morbid mental traits where none exist, and thereby cannot view social questions in a true light. Undoubtedly the modern psychologist does tend to see abnormal characteristics in the criminal, the tramp, and the prostitute in his mental analysis of such types, but his scientific findings have their prophylactic applications which would enhance social conditions if only he were listened to.

Though we pride ourselves on the excellence of administrative justice in this country, a very small amount of reflection should enable us to see that we treat the crime and not the criminal, and the system of to-day of so-called justice only tends to render the delinquent still more antisocial. Not only should a judge have some psychological training, but an expert psychiatrist should be constantly consulted on the grave question of responsibility, upon which the law takes an impossible view. The daily press constantly gives us details of palpable miscarriages of justice which the force of public opinion must cry out against as enlightenment comes about. Only a short time ago a man was given two years' imprisonment in the second division even though he had been previously in Broadmoor Criminal Lunatic Asylum, and also at Hanwell Asylum, and was described by the prison doctor as mentally defective, a moral imbecile, and lacking in self-control! How is such a man helped by such treatment? On this point we must again revert to America.

At the great criminal prison of Sing Sing in New York there has been initiated a psychiatric clinic under the ægis of the National Committee of Mental Hygiene, where the procedures for the classification and disposal of prisoners have met with unqualified success through the careful and excellent work of the director, Dr. Bernard Glueck. In a study of 608 admissions* Glueck found that 66·8 per cent. had shown abnormal conduct through life; 59 per cent.

* B. Glueck, "A Study of 608 Admissions to Sing Sing Prison," *Mental Hygiene*, vol. ii., No. 1, January, 1918.

showed deviation from normal mental health; 28·1 per cent. showed a degree of intelligence of a child of twelve or under; 18·9 per cent. were constitutionally inferior or psychopathic; and 12 per cent. had definite mental disease or deterioration. Such statements speak for themselves, and must mitigate to a very large extent the pride we have felt in the law's treatment of our fellow-man.

I must, before concluding, interpolate a few remarks on the question of the use of mechanical restraint in modern psychiatric treatment. It was, indeed, natural that a reaction should arise in this respect after the abolition of the barbarous treatment to which the insane had been previously subjected, but on mature reflection at the present day, in the light of scientific reason apart from emotional considerations, have we not gone to an extreme in the opposite direction, which by no means has always, in my opinion, redounded to the welfare of the patient? This point has been the more forcibly brought to my mind because at "D" Block, Netley, which has been a Clearing Hospital only, mechanical restraint has been freely used in order to be in a position to hand over violent patients elsewhere within a few days without having done themselves an injury. The means used were humane enough. The restraint consisted of a canvas suit with blind sleeves which could be tied together if necessary. I hold that *in suitable cases* such mechanical restraint is needful, is not only not prejudicial to the patient's mental or physical welfare, but is often definitely calculated for a time to do much good. So constantly one sees the fact vaunted in the annual reports of asylums: "No mechanical restraint has been used during the year." This statement is presumably rendered with pride, and evidently credit is thereby gained. One would find on analysis that restraint had been used many times, but not in the form of apparel or apparatus, but by the manual restraint of nurses or attendants. This continual manual restraint is far more harmful than that of a jacket, for in many cases it only enhances the delusional ideas of personal hostility and persecution, and is by no means good for the attendants, whose temper is thus too often sorely tried. Drug restraint is still more common, and the not infrequent habit of dredging the patients who are excited with narcotics is greatly to be deprecated. I aver, therefore,

that more mechanical restraint should be used, and without that dire fear that something wrong or criminal is thereby being done and that the Board of Control will at their visit bring charges of inhuman treatment. I have seen physical harm result to patients because of its non-use, septic wounds appear, and even death result thereby, which might all have been obviated had it not been for this false bogey of restraint, which is by some not spoken of except with bated breath. As to which cases would be most suitable for mechanical restraint is, of course, debatable. Roughly, they would comprise the acute confusional cases, which are more or less quite inaccessible, cannot be in any way reasoned with, which evince great excitement and violence not ameliorated by simple measures; some manics not otherwise restrainable, and who may injure themselves; certain psychopathic inferiors who have unreasoned, excited, and dangerous phases; and perhaps some delirious cases of general paresis. Each case, however, should be treated on its individual merits. In correctly chosen cases only good would accrue, but the psychiatrist must know his business and not merely adopt such treatment to save trouble irrespective of the patient's welfare. This question requires reconsideration by the alienist world.

In conclusion, it were easy for the psychiatric enthusiast to show how in diverse important departments of social life his work might greatly aid the development of civilization towards its betterment, and thus smooth life's rough way. His voice at present seems to cry out in the wilderness, though there are portents which give him hope. The late Great War has given a stimulus to thought for the future, and more willing ears are extended to anyone who may by new ideas of reform restore the almost lost faith in worldly ideals. That the psychologist and psychiatrist can materially aid in the world's organization and reconstruction is certain. At any rate, there are many reasons for believing that, largely through the late war, the future holds out a far finer prospect in mental medicine both for physician and patient.